EXHIBIT 11

UNITED STATES DISTRICT COURT SOUTHERN DISTRICT OF NEW YORK

IN RE: Acetaminophen – ASD-ADHD Products Liability Docket No. 22-md-3043 (DLC) Litigation

This Document Relates To: All Cases

AMENDED RULE 26 EXPERT REPORT OF DR. ERIC HOLLANDER, M.D., DFAPA, FACNP

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I. EXECUTIVE SUMMARY

The following amended report is provided pursuant to Rule 26 of the Federal Rules of Civil Procedure. The materials that I have considered in forming my opinions are included in this report and within my materials considered list. I have also reviewed the expert reports of Dr. Andrea Baccarelli, M.D., PhD (epidemiology), Dr. Robert Cabrera, PhD (teratology and genetics), Dr. Brandon Pearson, MSc, PhD (toxicology), and Dr. Stan Louie, PharmD (pharmacology), and all materials considered cited therein. I have based my opinions on my background, education, experience, and knowledge, my own review of the medical and scientific literature, as well as the materials provided to me.

I am licensed psychiatrist with expertise in psychopharmacology and neuropsychopharmacology. I have been asked to review the medical and scientific literature and to apply my professional experience and judgment to opine about the interconnectedness of various neurodevelopmental disorders, including Autism Spectrum Disorder (ASD) and Attention-Deficit/Hyperactivity Disorder (ADHD); whether the scientific evidence regarding the association between prenatal exposure to acetaminophen ("APAP") and neurodevelopmental disorders informs the question of whether prenatal exposure to APAP can cause the neurodevelopmental disorders of ASD and ADHD; and to assess whether there are plausible biological mechanisms to explain how APAP can cause the neurodevelopmental disorders of ASD and ADHD. To support my analysis and opinion, I provide an overview of the following: diagnostic criteria for ASD and ADHD, including DSM-IV, DSM-IV-TR, and DSM-5 diagnostic criteria and ICD classifications; the role of genetics and environmental factors in neurodevelopmental disorders; the overlap between ASD and ADHD established through a transdiagnostic approach; pathophysiology of neurodevelopmental disorders; and neuropsychopharmacological analysis of prenatal exposure to APAP and pharmacological effects on neurodevelopment.

ASD and ADHD are highly heterogenous both in terms of etiology and presentation. In other words, there is no single cause or risk factor, and the disorders manifest in a wide variety of symptoms that have significant, lifelong impacts on individuals, their families, and society as a whole. Because of the variability in ASD and ADHD, treating and researching these conditions is highly complex and requires expertise beyond the traditional boundaries of psychiatric and psychological specialties. Thus, transdiagnostic approaches provide valuable insight.

The transdiagnostic process refers to a mechanism that underlies and connects a group of disorders that transcends traditional diagnostic boundaries. For example, recent transdiagnostic research shows that neurodevelopmental disorders including ASD and ADHD share important neural, genetic, physiological, structural, and psychological traits (Barch, 2020). Both disorders are known to overlap with each other and other neurodevelopmental, psychiatric, and medical disorders. A recent functional magnetic resonance imaging (fMRI) study supports the idea that certain traits of neurodevelopmental disorders transcend traditional diagnostic categories. That study compared images of the brains of children diagnosed with ASD, ADHD, or OCD with those of neurotypical children and identified brain-based subgroups with similar biology among the children with ASD, ADHD, or OCD (Vandewouw et al., 2023). This result was consistent with observed symptomatic commonalities among the disorders indicating alterations in the brain's resting-state functional network (Vandewouw et al., 2023).

Based on my experience and expertise, when analysing causal associations between a toxic exposure and neurodevelopmental disorders such as ASD and ADHD, it is appropriate to consider comprehensive evidence that examines a variety of neurodevelopmental symptoms that could be

associated with ASD and ADHD, and to not limit the review to studies and analyses that solely assess ASD and ADHD diagnoses. Across neurodevelopmental disorders, there is often overlap of symptoms, and neurodevelopmental disorders frequently co-occur. This is true regarding the specific analysis of whether there is a causal association between prenatal exposure to APAP and the neurodevelopmental disorders of ASD and ADHD. As a medical doctor who has treated and researched ASD and ADHD using a holistic, transdiagnostic approach, I have reviewed extensive medical literature from various specialties that assess the impact of prenatal APAP exposure on neurodevelopment. As a researcher and clinician, the volume and breadth of these studies with consistent findings, is notable. The entirety of that literature, as effectively summarized and analyzed in the other expert reports submitted in this case, is relevant to the question of whether APAP can cause the neurodevelopmental disorders of ASD and ADHD. In fact, Johnson & Johnson reviewed broad neurodevelopment studies when assessing the causal association between prenatal use of APAP and the neurodevelopmental disorders of ASD and ADHD (Exhibit 63 to Deposition of Exhibit 80 to Deposition 90 to \$1.00 to \$

In addition, I reviewed the scientific evidence to assess whether there was a plausible biological mechanism by which prenatal use of APAP could impact fetal brain development and cause neurodevelopmental disorders. To address this issue, I provide a background on APAP and how I have recently discovered that APAP's profile as a safe drug for pregnant women may not be as accurate as has been represented to clinicians, like myself, and to the public. In fact, the label for Ultracet, which is a combination of APAP and another drug, tramadol, and is manufactured by a subsidiary of Johnson & Johnson, specifically warns of a fetotoxic animal study as it relates to fetuses. In addition, I outline several, plausible biological mechanisms that are informed by my research and review of the scientific evidence.

Based on my review of this scientific evidence, along with my education, training, decades of clinical and research experience, and a review of information from regulators and manufacturers, I state the following opinions:

- There is a strong interrelationship between the neurodevelopmental disorders of ASD and ADHD and across neurodevelopmental disorders.
- Based on this interconnectedness of neurodevelopmental disorders, including ADHD and ASD, it is appropriate to review the body of evidence that measures symptoms of neurodevelopmental disorders and to not limit the analysis to studies that focus on ASD and ADHD as specified outcomes when evaluating the potential causal association between prenatal APAP exposure and ASD and ADHD in offspring.
- I reviewed the underlying epidemiological literature regarding whether prenatal use of APAP can cause the neurodevelopmental disorders of ASD and ADHD, and that body of literature is consistent with my opinion that to fully investigate and address the question of whether prenatal use of APAP can cause the neurodevelopmental disorders of ASD and ADHD, scientists should look to the full body of neurodevelopmental studies.
- There are multiple, plausible mechanisms of action to explain how APAP can impact fetal brain development and lead to neurodevelopmental disorders in offspring.
- Depending on the timing and duration of APAP exposure to the developing brain,
 if the suspect mechanisms of injury occur, then one would expect a wide variety of
 diffuse neurologic symptoms/injuries when the brain develops.

Based on my review of the literature, the expert reports, and my decades of clinical
experience, I would not advise my pregnant patients to take APAP unless they have
fever and to use at the lowest effective dose for the shortest time possible and the
lowest possible frequency.

I express the opinions set forth herein to a reasonable degree of medical and scientific certainty. In reaching these conclusions, I have followed the same or similar procedures that I employ in my clinical practice and in the clinical study of neurodevelopmental disorders, including ASD and ADHD. I have not used special or different procedures in preparing this report.

II. QUALIFICATIONS AND EXPERIENCE

In my work and career, I primarily have specialized in the field of psychiatric medicine, neurodevelopmental disorders, and neuropsychopharmacology.

I am a psychiatrist licensed to practice medicine in the state of New York. I was board certified in 1987 by the American Board of Psychiatry and Neurology. I am a Professor of Psychiatry and Behavioral Sciences, and the Director of the Autism and Obsessive-Compulsive Spectrum Program, at the Psychiatry Research Institute of Montefiore-Einstein at Albert Einstein College of Medicine (AECOM) and Montefiore Medicine, in the Bronx, New York. I am a fellow of the American College of Neuropsychopharmacology (ACNP), and a Distinguished Lifetime Fellow of the American Psychiatric Association (APA). I am the past president of the International Society of Research in Impulsivity (ISRI).

I have an extensive background in psychopharmacology and neuropsychopharmacology. Neuropsychopharmacology combines neuroscience with pharmacology and studies the effects of drugs on neural mechanisms that influence behavior. I completed a Fellowship in Psychopharmacology at Columbia University and was the Principal Investigator for the National Institute of Mental Health (NIMH) Psychopharmacology Training Program.

Prior to 2009, I was an Esther and Joseph Klingenstein Professor of Psychiatry and Chairman of Psychiatry at Mount Sinai School of Medicine. I was also an attending psychiatrist at Mount Sinai Hospital from 1993 to 2008. From 1986 to 1993, I was faculty at Columbia University College of Physicians and Surgeons and the New York State Psychiatric Institute, and Associate Professor of Clinical Psychiatry.

I received my Medical Degree in 1982 from the State University of New York, Downstate Medical College, Brooklyn, New York. I served my Internship in Internal Medicine at Mount Sinai Hospital in New York, New York, from 1982 to 1983. I was a Resident in Psychiatry at Mount Sinai from 1983 to 1986, serving as Chief Resident–Psychiatry Research from 1985 to 1986. From 1986 to 1988, I was a NIMH Psychiatry Research Fellow at Columbia University College of Physicians and Surgeons. I was a Dana Foundation Fellow at Columbia from 1988 to 1989, and practiced as a NIMH Research Scientist Development Award recipient there from 1988 to 1993.

I have received numerous awards and honors throughout my career, including Best Doctors in New York and Best Doctors in the United States from 2007 until present, and a National Alliance for Research on Schizophrenia & Depression (NARSAD) distinguished investigator award in 2009. I am an inventor on several patents related to, among other things, oxytocin or memantine in autism and other disorders.

I have published more than 500 peer-reviewed scientific papers in professional literature sources. I have edited 20 books, including the Textbook of Autism Spectrum Disorders, 2nd edition (American Psychiatric Publishing, 2022), Textbook of Autism Spectrum Disorders, 1st edition (American Psychiatric Publishing, 2011), three editions of the Textbook of Anxiety, Trauma, and OCD Related Disorders (American Psychiatric Publishing, 2002, 2009, 2020), and the Clinical Manual of Impulse Control Disorders (2006).

I am the Chair of the Board of Directors of the International College of Obsessive Compulsive Spectrum Disorders (ICOCS). The ICOCS is primarily aimed at advancing, promoting and facilitating research into the causes and consequences of obsessive compulsive disorder (OCD) and obsessive compulsive spectrum disorders. The organization intends to aid and stimulate mental health professionals and others to develop research projects in the field, and to help coordinate research efforts amongst members. The organization's website¹ is dedicated to news, research findings, funding opportunities and new developments in the study of OCD and OC spectrum disorders. The organization holds scientific meetings annually for ICOCS members and other interested clinicians and researchers. The ICOCS also increases public health awareness of OCD and OC spectrum disorders with the hope of improving diagnosis and encouraging better deployment of resources for assessment and treatment. Its members offer advice to legislative bodies and government agencies and cooperate on national and international treatment guidelines.

From 2002 to 2007, I served the APA as the Chair of the Diagnostic and Statistical Manual of Mental Disorders ("DSM-5") Research Planning Agenda for Obsessive Compulsive Behavior Spectrum Disorders, and then from 2007 to 2009 as a member of the DSM-5 Anxiety, Obsessive-Compulsive Spectrum, Post-Traumatic and Dissociative Disorders Workgroup, and the Behavioral and Substance Addictions Workgroup. In 1998, I served as the Workgroup Chair for the Impulse Control Disorder Section of the DSM-IV-TR. From 1992 to 1994, I served as a member of the Obsessive-Compulsive Disorder Workgroup for the DSM-IV. In 2006, I edited the APA Publishing Clinical Manual for Impulse Control Disorders. I was also a member of the editorial board of the

¹ http://www.icocs.org.

APA Treatment Manual for Obsessive Compulsive Disorders, and the 2023 CANMAT/ICOCS Practice Guidelines for Obsessive Compulsive and Related Disorders.

I have served as the principal investigator on a number of federal grant funded research projects. I have received orphan drug grants from the Food and Drug Administration to study new treatments for Prader Willi Syndrome (a neurodevelopmental disorder and syndromic form of ASD), body dysmorphic disorder, child/adolescent autism, and adult autism, and a grant from the National Institute of Drug Abuse for a study on the neurobiology of pathological gambling. I have received several grants from NIMH and the National Institute of Neurological Disorders and Stroke to develop treatments for borderline personality disorder, adolescent body dysmorphic disorder, and autism. I was the principal investigator of the Autism Clinical Trials Network and Chair of the eight centers participating in the National Institutes of Health Studies to Advance Autism Research and Treatment (NIH STAART) Autism Steering Committee. I am involved in research funded by federal institutes, not-for-profit foundations, and by industry on the neuropharmacology, neuropsychiatry, functional imaging, and treatment of multiple disorders including, but not limited to, autism spectrum disorder, obsessive-compulsive disorder, impulsive/aggressive personality disorders, and obsessive-compulsive-related disorders, such as body dysmorphic disorder, attention deficit hyperactivity disorders, impulse control disorders, problematic use of the internet, and pathological gambling. I have served as Principal Investigator for numerous federal grants in Autism Spectrum Disorders, including active grants with NIH STAART studies, DOD CDMRP Autism Research Program, Foundation for Prader Willi Research, Roche Pharmaceuticals, and FDA Orphan Products Division grants. I have previously served as Principal Investigator for federal grants including the NIH Greater New York Autism Center of Excellence, the NIMH Research Training Grant in Psychopharmacology and Outcomes Research,

and the Autism Clinical Trials Network. I have received funding from the Department of Defense for the study of cannabidivarin (CBDV) in ASD, and from the Orphan Products Division of the FDA for the study of intranasal oxytocin in Prader-Willi Syndrome.

I have over 30 years of clinical and translational research experience. I currently serve as the Director of Spectrum Neuroscience and Treatment Institute (SNTI). SNTI offers state of the art, interdisciplinary and personalized integrated treatments for obsessive-compulsive disorders (OCD), anxiety disorders, autism spectrum disorders, and attention-deficit/hyperactivity disorders.

I have used my clinical experience and training to treat people with ASD, ADHD, OCD and related conditions, in addition to Prader-Willi Syndrome, depression, body dysmorphic disorder, anxiety disorders (including Generalized Anxiety Disorder, Social Anxiety and Panic Disorder), depersonalization disorder, cataplexy, trichotillomania, sleep disorders and pain disorders.

In my research and clinical work, I routinely make assessments of potential causal associations between a substance and particular pharmacological effect. As a practitioner who specializes in neuropsychopharmacology, I have undertaken these types of assessments for more than two decades. As a clinician and researcher, my work involves diagnosing neurodevelopmental disorders, including ASD and ADHD, as well as understanding and examining the underlying causes and mechanisms of those disorders. My education, training, and decades of experience in this field qualifies me to render the opinions included in this report.

As a psychiatrist, I have extensive experience diagnosing and treating neurodevelopmental disorders. The experience has led me to identify commonalities among many neurodevelopmental disorders based on the symptoms I evaluate, the assessments and diagnostic tools I use, and the clinical and pharmacological interventions I recommend. While ASD and ADHD in particular are

highly heterogenous, my experience has shown they are likely to overlap symptomatically or be comorbid with each other or with other neurodevelopmental disorders. The scientific research on this topic confirms my experience.

Further, my own clinical and translational research in neuropsychopharmacology enhances my clinical experience by allowing me to assess and draw conclusions about the effects of drugs (like APAP) on neurodevelopmental disorders, including ASD and ADHD. I have decades of experience understanding and examining the underlying causes and mechanisms of neurodevelopmental disorders. In this report, I apply my extensive experience and knowledge to arrive at the opinions stated above.

III. OVERVIEW OF NEURODEVELOPMENTAL DISORDERS, INCLUDING ASD AND ADHD

In my practice as a psychiatrist with a focus in neuropsychopharmacology, I routinely assess neurodevelopmental causation issues in my patients. This includes reviewing, analyzing, conducting, and collaborating with colleagues on clinical and epidemiological studies as both a clinician and clinical researcher. Epidemiological studies, which are derived from observational data experienced by many patients, support my understanding of psychiatry, pharmacology, and neurodevelopment especially at it pertains to causation issues. My expertise and experience allow me to understand and evaluate the epidemiological studies that assess the association between prenatal use of APAP and neurodevelopmental disorders like ASD and ADHD.

ASD and ADHD are permanent neurodevelopmental disorders that are primarily associated with the functioning of the neurological system and the brain. Neurodevelopmental disorders are characterized by developmental deficits that impair personal, social, academic, or occupational functioning (DSM-V). Children with neurodevelopmental disorders can experience difficulties with language and speech, motor skills, behavior, memory, learning and other functions.

Abundant research across decades has shown that children with better attention and executive function do better in every aspect of life, not only in school, but also regarding income earning potential and adult physical health (Liew et al., 2016; Christakis et al., 2016; Moffitt et al., 2011). Both ASD and ADHD can have significant detrimental life impact on the afflicted child and their families in adjusting and supporting such neurodevelopmental disorders, including significant detrimental impact on learning, on social and communication abilities, and on planning, organizing and coping with life challenges, among other facets of life, even for those with above average intelligence.

A. Transdiagnostic Approaches to Developmental Disorders

Although traditional psychiatric and psychological approaches involve focusing on a specific diagnostic category, recent work in the field has demonstrated that these artificial boundaries do not always reflect the constellation of symptoms I see in my patients. The biological factors behind these symptoms cut across traditional diagnostic boundaries, as demonstrated by recent transdiagnostic research that shows shared neural, genetic, physiological, structural, and psychological traits (Barch, 2020). Transdiagnostic is defined as a proposed mechanism that underlies and connects a group of disorders. This process has been the focus of newer research, with the NIMH even creating a Research Domain Criteria (RDOC) Initiative to help provide an organizational structure that considers mental health, neurodevelopment, and psychopathology in the context of major domains of neurobehavioral functioning, rather than within traditional diagnostic categories (*About RDoC*, n.d.).

Both ASD and ADHD are known to overlap and/or be comorbid with each other, in addition to many other neurodevelopmental, psychiatric, and medical disorders. For example, in Vandewouw et al. (2023), researchers compared functional magnetic resonance imaging (fMRI) of the brains of children diagnosed with ASD, ADHD, or OCD to those of children who were

typically developing. They identified brain-based subgroups with similar biology overall in the children with the neurodevelopmental disorders compared to the healthy control children. These brain-based subgroups did not align with current diagnostic categories (Vandewouw et al., 2023). Hyperactivity, externalizing behaviors, conduct problems, emotion regulation difficulties, and impulsivity are observed to be shared characteristics across neurodevelopmental conditions and were associated with alterations in the brain's resting-state functional network, including widespread increased segregation and patterns of both increased and decreased integration (Vandewouw et al., 2023). As a result of both this and other studies, a holistic and transdiagnostic approach that uses continuous measures of behavior is necessary to fully understand the highly heterogenous conditions of ASD and ADHD. Likely for this reason, Johnson & Johnson followed this approach and reviewed broad neurodevelopment studies when assessing the causal association between prenatal use of APAP and the neurodevelopmental disorders of ASD and ADHD (Exhibit 63 to Deposition of

B. Autism Spectrum Disorder

B.1. DSM and ICD Diagnostic Criteria and Classification

ASD is a neurodevelopmental disorder characterized by persistent deficits in social communication and social interaction, and the presence of restricted and repetitive patterns of behavior, interests, and activities. There is an estimated 2.8% worldwide prevalence rate of ASD, with the CDC reporting that 1 in 36 children have an ASD diagnosis (Maenner et al., 2020). ASD occurs in all racial, ethnic, and socioeconomic groups and is reported to be nearly four times more common among males than among females. However, this gender gap continues to narrow, and ASD is often underdiagnosed in females. Due to the heterogeneity of ASD, the presentation of symptoms varies across individuals and may be similar to, or overlap with, other neurodevelopmental and psychiatric disorders.

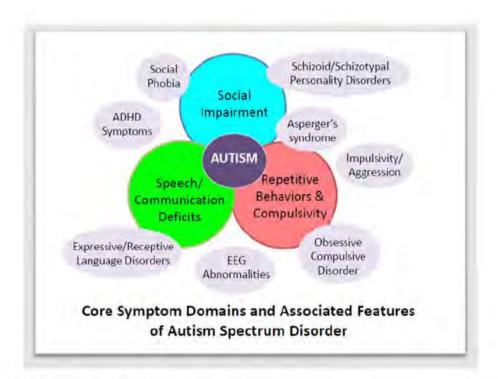
The DSM-IV was published in 1994, with a revised version released in 2000 (DSM-IV-TR). The current version of the DSM is the DSM-5, which was published in 2013. As the studies discussed in this report include individuals diagnosed under the diagnostic criteria set forth in either the DSM-IV or DSM-5, I discuss the diagnostic criteria set forth in each edition. The complete DSM-5 and DSM-IV diagnostic criteria for autistic disorder and ASD are excerpted in **Appendix 1.**

Several important changes relating to ASD and ADHD were made to the DSM-5 compared to the DSM-IV-TR (Doernberg & Hollander, 2016). Notably, the chapter of the DSM-IV-TR titled "Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence"—which included autism and a host of other conditions—was deleted and replaced with a chapter titled "Neurodevelopmental Disorders." Regarding autism in particular, the DSM-5 removed the five separate pervasive developmental disorders (autistic disorder, Asperger's disorder, Rett's disorder, childhood disintegrative disorder, and PDD Not Otherwise Specified, or NOS) and created the "spectrum" diagnosis, reducing autism to two core domains (DSM-IV-TR; Doernberg & Hollander, 2016).

As noted above, in the DSM-IV-TR, the autism spectrum disorder diagnosis was not singular. Instead, three different diagnoses existed separately: Autistic Disorder (299.0), Asperger's Disorder (299.80), and Pervasive Developmental Disorder – Not Otherwise Specified (PDD-NOS), including atypical autism (299.80). The Autistic Disorder diagnosis was generally given to those who presented with more severe forms of autism, while the PDD-NOS diagnosis was for those with less severe forms. Asperger's Disorder was generally given to those with higher functioning autism without a history of speech and cognitive delays.

The ICD is a globally-accepted framework for medical diagnosis (World Health Organization, *International Statistical Classification of Diseases and Related Health Problems (ICD)*). Developed and maintained by the WHO, its primary purpose is classification, in contrast to the DSM, which focuses primarily on diagnosis (Doernberg & Hollander, 2016). The ICD has four distinct purposes: facilitating clinical utility by establishing a shared diagnostic language, addressing insurance-related requirements, addressing legal considerations, and ensuring long-term support for research endeavors (Doernberg & Hollander, 2016). As a comprehensive medical system, the ICD encompasses specifiers for identifying underlying causes and mirrors the classification approach used for all other medical conditions (Doernberg & Hollander, 2016). Many of the epidemiological studies that assess the causal association between prenatal use of APAP and neurodevelopmental disorders use the ICD-9 and ICD-10 classifications to identify diagnoses. The complete list of elements of the ICD-9 and ICD-10 are excerpted in **Appendix 1**.

A final issue relating to defining and classifying ASD is use of the term "regressive autism" in some older literature. This is a descriptor previously used to describe children who appeared to meet all developmental milestones until approximately age 2, but then suddenly have a rapid loss of skills. In recent years, this term has lost favor, and top minds in the field, including Sally Ozonoff and Catherine Lord, have confirmed that one cannot split individuals with autism into the camps of regressive or non-regressive. Instead, it is well-recognized that each child presents with differing signs of ASD early in life, and there are a variety of onsets. This diagnostic term is no longer used in the primary literature (*Rethinking Regression in Autism*, 2017).



B.2. Sex Differences in ASD Diagnoses.

ASD is reported to be nearly four times more common among males than among females, but some evidence shows the gap is narrowing. The difference in diagnostic rate is also apparent in some research relating to ASD presentation and symptoms. Some research shows no sex differences in restricted and repetitive behaviors (RRBs) for males and females with ASD, while other studies show that RRBs present more subtly in females with ASD (Jamison et al., 2017). Females with ASD are shown to present with more socially acceptable restricted interests and greater play and imaginative skills which may mask unusual behaviors, particularly during childhood (DaWalt et al., 2020; Jamison et al., 2017).

Similar to rates in typically-developing adolescents and adults, females with ASD are at a greater risk for depression and anxiety and present with more internalizing conditions compared to both typically-developing males and males with ASD (DaWalt et al., 2020; Jamison et al., 2017). Additionally, possibly due to implicit biases, females need to present with more severe disruptive behaviors than males in order to receive a diagnosis of ASD. Females socialized to internalize

emotions and behaviors may have better adaptive skills, allowing them to suppress symptoms and fit in until social pressures become too great (Jamison et al., 2017). As a result, depression and anxiety may initially appear as the primary diagnosis during the challenging adolescent developmental period or adulthood (DaWalt et al., 2020; Jamison et al., 2017). Thus, diagnosis of ASD may be late or nonexistent in females.

Research aimed at understanding how sex differences influence social and communication function in these disorders is limited and results are conflicting. Mahendiran et al. investigated potential sex differences across age in social adaptive function in ASD and ADHD compared to typically developing controls (Mahendiran et al., 2019). Participants included 115 youth with ASD, 172 youth with ADHD, and 63 typically developing controls, aged 7 to 13 years, with 75% males. Social adaptive function was assessed using the Adaptive Behavior Assessment System-Second Edition (ABAS-II). Proportions of adaptive behaviors in each skill area were analyzed as binomial outcomes through logistic regression, while accounting for age and investigating age-by-sex interactions. An additional analysis explored the impact of controlling for core symptom severity on the observed sex effect.

In the ASD group, Mahendiran et al. observed significant interactions between sex and age in the areas of communication (p = 0.005), leisure (p = 0.003), and social skills (p < 0.0001) (Mahendiran et al., 2019). In these areas, females scored lower (indicating poorer function) compared to males at older ages, despite females performing better at younger ages. Significant sex-by-age interactions were also found between ASD and typically developing controls in the social and leisure domains. Typically developing females showed better scores at older ages compared to younger ages. These findings highlight the importance of considering a

developmental perspective when examining sex differences, which may have implications for diagnosis, prognosis, and treatment.

B.3. Associated Features and Co-morbid Psychiatric and Medical Disorders

Individuals with ASD often present for treatment for symptoms that fall outside of the core symptom domains, including aggression, irritability and self-injurious behaviors. Approximately 70% of individuals with ASD have a co-morbid mental health diagnosis, and 40% have two or more co-morbid mental health diagnoses. ADHD is the most frequent comorbid disorder with ASD.

Psychiatric comorbidities are common in ASD and are associated with increased symptom severity across the lifespan. Anxiety and depression are frequently associated with ASD (Gotham et al., 2015; Towbin et al., 2005). As compared to the general population, those with ASD have significantly higher rates of suicide, with one surveyed sample noting that 66% reported suicidal ideation (Cassidy et al., 2014). Bipolar disorder and ASD often overlap as they share common etiological factors (Sullivan et al., 2012). Individuals with ASD and comorbid OCD may present with unique behavioral profiles and tend to exhibit higher self-reported obsessive-compulsive symptoms than individuals diagnosed with only OCD, with notably elevated obsessing, ordering, and checking symptoms (Jiujias et al., 2017). The high rate of comorbid psychiatric illness in the ASD population, including depression and anxiety, significantly contributes to the increased risk for Substance Use Disorders.

B.4. Role of Genetics

There are no current genetic markers or tests that confirm a diagnosis of idiopathic ASD. Genetic testing is only used to rule out syndromal forms of ASD, not to confirm an ASD diagnosis. Rather, the large number of genetic variables increases risk and vulnerability to environmental

insult. Genes account for up to about 85 percent of autism's heritability, but only about 10 percent of individuals with ASD have an identifiable genetic cause ('Polygenic Risk Scores' for Autism, Explained, 2023).

Common variants working together may account for almost half of autism's genetic basis, and each person has a unique set of variants that affects their autism risk. The multiple-hits theory of autism can explain why the same mutation can lead to different sets of traits in two people, as environmental insults during various times of development (in utero, early childhood, adolescence) causes changes in gene expression at the epigenetic level (*The Multiple Hits Theory of Autism*, *Explained*, 2019).

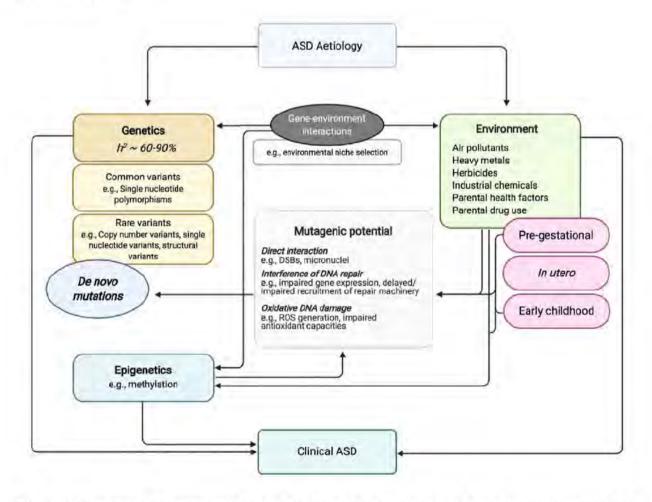


Fig. 1. Diagrammatic representation of the interplay between genetic and environmental risk factors in etiology of ASD (Pugsley et al., 2022).

Due to the heritability of ASD, siblings of individuals with ASD may be at a higher risk of developing ASD or having another neurodevelopmental or psychiatric illness (Jokiranta-Olkoniemi et al., 2016; Shephard et al., 2017). Family members of those with ASD are at a higher risk of having learning and language problems, and mood and anxiety disorders (Jokiranta-Olkoniemi et al., 2016; Sandin et al., 2014; Volkmar et al., 2014). There are also higher rates of gastrointestinal and sleep disorders in the siblings and parents of those with ASD (Aldinger, Lane, Veenstra-VanderWeele, et al., 2015).

During clinical assessment, genetic testing may be completed to rule out syndromal causes of ASD, including Fragile X Syndrome, Rett Syndrome, Tuberous Sclerosis Complex, Prader-Willi Syndrome and Angelman Syndrome. These syndromes affect 10% of individuals with a known identifiable genetic cause of ASD.

Although a large fraction of ASD's genetic roots comes in the form of single nucleotide polymorphisms (SNPs), each variant confers only a small increase in a person's chance of having ASD. Assays may be completed in research studies to scan for SNPs in those with ASD to determine which occur the most frequently. The polygenic risk score, the weighted sum of all the common variants, can then be calculated with the hope that in the future this will aid in the diagnosis of ASD. However, much more work needs to be completed before this is of use in clinical practice. Over 500 genes have been associated with ASD, with 58 common variants identified within 27 genes. Common variants explain 40% to 60% of the heritability of ASD.

B.5. Environmental Factors

Recent studies suggest that exposure to environmental factors may account for up to 40% to 50% of the variance in ASD liability. Liability is defined as all the genetic and environmental factors that contribute to the development of a multifactorial disorder, like ASD. There are

variations in the amount of evidence for each environmental factor, with some supported by association, in vitro and in vivo studies, and others with weaker evidence. Environmental factors can be divided into prenatal exposures and maternal conditions, perinatal risk factors, and parental risk factors.

Prenatal exposures and maternal conditions include, but are not limited to, maternal depression and autoimmune disease, exposure to antidepressants and anticonvulsant drugs in utero, gestational diabetes, fetal distress and cesarean delivery, viral and bacterial infections, prenatal APAP exposure, metal exposure, and decreased exposure to folic acid and other macronutrients in utero. It is difficult to separate the potential effects of SSRIs on the fetus from the mother's underlying psychiatric condition, including depression or untreated depression. Systematic reviews and metanalyses have indicated that the maternal use of SSRIs could be associated with as high as a 50% increase in ASD risk, but maternal mental health could not be removed as a confounding factor (Kobayashi et al., 2016; Andalib et al., 2017). It is clear that serotonin metabolism and altered serotonergic pathways are associated with ASD risk (Anderson et al., 2008), and animal models exposed to prenatal SSRIs have demonstrated adverse neurodevelopmental outcomes, indicating they might have a causal role. However, genetic susceptibility due to underlying maternal mental health is also supported by the continued increased risk of psychiatric disorders in children whose mothers had discontinued antidepressant use during pregnancy (Liu et al., 2017). Thus, although an increased risk of psychiatric disorders is observed in children exposed to antidepressants in utero, it is suspected this is largely due to the severity of the mother's underlying psychiatric disorder, as they are more likely to continue treatment during pregnancy.

Epidemiological studies have also shown that children exposed in utero to valproic acid, an antiepileptic and mood stabilizer, in the first trimester are at higher risk of developing ASD. These results have been further confirmed by both animal and human studies, and rodents exposed to valproic acid have symptoms that mirror those observed in their human counterparts with ASD, including social impairments, repetitive behaviors and cognitive inflexibility (Chaliha et al., 2020).

Maternal autoimmune disease or exposure to viral and bacterial infections during pregnancy are also associated with an increased risk of ASD in offspring. The elevated inflammatory markers and antibodies in pregnant women in response to an infection are noted to interfere with in utero development, increasing ASD risk. There is also an association between ASD and family history of autoimmune diseases. The maternal immune activation (MIA) hypothesis confirms the importance of the maternal immune system and the increased risk of ASD and other psychiatric/neurodevelopmental disorders in offspring (Wu et al., 2015; Comi et al., 1999; Atladóttir et al., 2009; Chen et al., 2016).

An umbrella review conducted by Kim et al. systematically evaluated relevant metaanalyses to study the strength and validity of certain environmental risk factors or biomarkers of
ASD (Kim et al., 2019). The authors identified 46 eligible articles on 52 biomarkers and 67
environmental risk factors. The authors' analysis provided *convincing evidence* (Class I) in relation
the association between ASD and maternal factors, including age, and features of metabolic
syndrome, and the use of antidepressants like SSRIs. Additionally, the authors' analysis provided *highly suggestive evidence* (Class II) showing associations between ASD and higher paternal age,
maternal exposure to autoimmune disease, and APAP exposure during pregnancy. The authors
stated, however, that the results should be interpreted with caution given the statistical methods
and biased tests used.

A meta-analysis of case-control studies found an increased risk of ASD of 62% in offspring with mothers with diabetes compared to those without (Wan et al., 2018). Additionally, gestational diabetes has also been associated with an increased risk of ASD, in addition to other adverse pregnancy outcomes. It is hypothesized that the oxidative stress and hormonal and metabolic abnormalities caused by gestational diabetes interferes with in utero development (Gardener et al., 2009; Xu et al., 2014). Parental age may be a confounder in the relationship of ASD risk to maternal pregestational or gestational diabetes.

Fetal distress is associated with multiple adverse outcomes, one of which may be an increased risk of developing ASD. Hypoxia, related to fetal distress, prolonged labor, cord complications, low Apgar score, maternal hypertension and cesarean delivery, are shown to increase dopaminergic activity, which could be related to dopaminergic overactivation in ASD, and increased ASD risk, although more work needs to be done examining this area (Gardener et al., 2009). Cesarean delivery has also been modestly associated with ASD in multiple studies (Curran et al., 2015).

Both increased exposure to toxic metals, and decreased exposure to those important to development, have also been suggested as playing a role in the pathogenesis of ASD. In a large mother-child cohort study, maternal erythrocyte lead concentrations in the second trimester were associated with an increase in the parent-related emotional problems subscale of the Strengths and Difficulties Questionnaire (SDQ) in both sexes, and in the total SDQ score in girls when assessed in mid-childhood (Campbell et al., 2021). Exposure to high levels of inorganic mercury has also been linked to an increased risk of ASD in offspring (Yoshimasu et al., 2014). There is also some research examining the effect of unbalanced metal levels on synapse formation, and the possible

therapeutic role of zinc supplementation (Hagmeyer et al., 2015), and the possibility it can reduce the risk of neural tube defects in offspring (Velie et al., 1999).

Exposure to organophosphates during pregnancy, including non-persistent organic pollutants (phthalates and bisphenol A), and persistent organic pollutants (DDT, PCB, PBDE) may also be linked to increased risks of offspring developing neurodevelopmental disorders, such as ASD, but more research is needed (Shelton et al., 2014).

Prenatal diet may also play a role in the etiology of ASD, and prenatal deficiencies of micronutrients have been associated with an increased risk of ASD. Folic acid is important to in utero development, and its use prenatally has protective effects, including reducing neural tube deficits. Adequate intake of folic acid and vitamin D, and folic acid supplementation, have been associated with a lower likelihood and reduced risk of ASD in offspring (Zhong et al., 2020; Liu et al., 2021).

Perinatal risk factors include, but are not limited to, low birth weight, preterm birth, and fetal growth restriction. These are the most studied ASD risk factors. Statistically significant associations have been found between ASD risk and low birth weight, neonatal anemia, umbilical cord complications, birth injury/trauma, maternal hemorrhage, caesarean section delivery, fetal distress, and blood group incompatibility (Gardener et al., 2009; Gardener et al., 2011; Wang et al., 2017). Low birth weight (< 2500 g) is an early indicator of an issue in the intrauterine environment and is a marker for high risk of multiple later neurological, psychiatric and neuropsychological problems, including cognitive difficulties, attention difficulties, social deficits, hyperactivity and learning difficulties (Hack et al., 2005). Only two epidemiological studies have found an increased risk of ASD associated with low birth weight when other risk factors are controlled for (Maimburg and Vaeth, 2006; Schendel and Bhasin, 2008). Preterm births often also

have low birth weight, and have been associated with developmental delays, intellectual impairments, and adverse health outcomes (Moster et al., 2008; Schothorst & van Engeland, 1996; Wood et al., 2000). One study demonstrated a seven-fold increase in ASD risk when the child was born before 31 weeks (Moster et al., 2008), while others have shown an increased risk at birth before 37 weeks after controlling for confounders (Durkin et al., 2008; Larsson et al., 2005). Growth restriction, a child being born small for their gestational age, is often due to factors that reduce in utero growth, including placental problems, maternal nutritional problems, and maternal infections. Three studies have found a significant association between growth restriction and ASD risk, with one study continuing to show a strong link even when preterm birth, low birth weight, and other risk factors were accounted for (Hultman et al., 2002; Larsson et al., 2005; Maimburg & Vaeth, 2006).

Parental risk factors include, but are not limited to, advanced maternal and paternal age, and maternal obesity. One of the most established environmental risk factors for ASD is parental age, and this environmental risk factor has also been linked to the development of schizophrenia, bipolar disorder and ADHD. A 10-year increase in maternal and paternal age has been associated with a 20% higher risk of ASD in children (Wu et al., 2017). Maternal age remains an independent risk factor for ASD even after adjustment for other potential confounders (Croen et al., 2007; Maimburg & Vaeth, 2006; Janecka et al., 2019; Grether et al., 2009; Durkin et al., 2008; Sandin et al., 2016; Glasson et al., 2004), and if all studies are taken into account it is possible that it increases the risk of ASD by approximately 50% when other confounders are also accounted for. Advanced paternal age has been associated with age-related methylation changes in sperm that increases ASD risk in offspring, and ASD offspring of older fathers are shown to have a reduced cortical thickness

in the right posterior ventral cingulate cortex (Atsem et al., 2016; Kojima et al., 2019). These results are supported by mouse models (Foldi et al., 2010; Sampino et al., 2014).

Meta-analyses have shown between a 28% and 36% increased risk of ASD in children with overweight and obese mothers, with a potential linear dose-response relationship between maternal BMI and risk of ASD (Wang et al., 2016). This connection still needs to be studied, as in another large study, the sibling analysis did not reveal any association between elevated BMI and ASD risk, even though there was a relationship at the population level (Gardner et al., 2015).

B.6. Major Hypotheses on Pathophysiology

The etiology of ASD is complex and involves genetic, epigenetic, environmental, metabolic, and immune-inflammatory factors (Hsiao et al., 2013; Loke et al., 2015). Metabolomic and lipidomic levels are altered in ASD (Aran et al., 2019; Brigandi et al., 2015; Likhitweerawong et al., 2021; Ming et al., 2012; Needham et al., 2020, 2021; Orozco et al., 2019; Smith et al., 2020; Tamiji & Crawford, 2011; Yui et al., 2016; Zou et al., 2021), and may be correlated with symptom severity. The polyunsaturated fatty acid (PUFA) metabolism that results in the production of eicosanoids may be overactive in ASD (Brigandi et al., 2015; Tamiji & Crawford, 2011).

This association between lipid metabolism and ASD is also supported by significant alterations of plasma omega-3 and omega-6 fatty acids, resulting in an imbalance in the ratio of omega-3/omega-6 PUFAs (Yui et al., 2016). This is important because APAP and its active metabolites, including AM404 impact lipid signaling in the CNS. Key metabolic pathways are also affected (Likhitweerawong et al., 2021; Ming et al., 2012; Needham et al., 2021; Orozco et al., 2019; Smith et al., 2020). The excitation/inhibition imbalance hypothesis of ASD may also be linked to metabolomics/lipidomics, as elevated lysophosphatidylinositol (LPI) induces cortical excitability due to its pro-excitatory and anti-inhibitory effects (Anavi-Goffer et al., 2012). Thus,

APAP and its active metabolite AM404 impact E/I imbalance due to its effects on lipid signaling pathways. Cortical excitability is also linked to other disorders characterized by inflexible thinking, like OCD (Greenberg et al., 2000).

Cortical excitability may be linked to altered cortical pathology including patchy disruption of cortical mini-columns in the frontal and temporal cortex, resulting in E/I imbalance, and manifest in increased propensity of seizures, hyperactivity, impulsivity and irritability, as described below in E/I imbalance. Individuals with intensely upregulated immune and metabolome genes in postmortem brain tissue may have a neuroinflammatory condition in which atypical microglial activation derails normal neurogenesis and synaptogenesis across various conditions, including ASD and other neurological and psychiatric conditions (Y. Chen et al., 2022). Most of the expression changes observed in brain tissue samples do not appear in gene expression patterns in blood samples from people with the same conditions.

These changes may not reflect the specific disorders, but rather a transdiagnostic endophenotype that cuts across conditions. There is significant evidence for immune dysfunction in ASD, including systemic inflammation, cytokine dysregulation and anti-brain autoantibodies (Lyall et al., 2014; Masi et al., 2017; Meltzer & Van de Water, 2016). Both prenatal and postnatal exposures to immune triggers may lead to an altered immune system and thus altered neurodevelopment (Fox et al., 2012). Individuals with ASD have impaired immune system regulation and heightened inflammatory processes demonstrated by altered cytokine and chemokine profiles (Ashwood et al., 2011) and increased microglial activation (Careaga et al., 2010; Goines & Ashwood, 2013; Hsiao, 2013; Masi et al., 2017; Onore et al., 2012; Pardo et al., 2005). Metabolomic and lipidomic levels are also altered in ASD (Aran et al., 2019; Brigandi et al., 2015; Likhitweerawong et al., 2021; Ming et al., 2012; Needham et al., 2020, 2021; Orozco et

al., 2019; Smith et al., 2020; Tamiji & Crawford, 2011; Yui et al., 2016; Zou et al., 2021), and may be correlated with symptom severity. The polyunsaturated fatty acid (PUFA) metabolism that results in the production of eicosanoids, inflammatory mediators that stimulate and modulate cytokine levels, may be overactive in ASD (Brigandi et al., 2015; Tamiji & Crawford, 2011). This association between lipid metabolism and ASD is also supported by significant alterations of plasma omega-3 (n-3) and omega-6 (n-6) fatty acids, resulting in an imbalance in the ratio of omega-3/omega-6 PUFAs (Yui et al., 2016).

Thus, APAP and its active metabolite NAPQI, which impacts inflammatory mediators may exert its effects via these mechanisms. Key metabolic pathways are also affected in those with ASD, including the end products of glycolysis (lactate/pyruvate), amino acid and TCA cycle metabolism and the carbon metabolism via folic acid-folate cycle (Likhitweerawong et al., 2021; Ming et al., 2012; Needham et al., 2021; Orozco et al., 2019; Smith et al., 2020). These studies also showed alterations in fatty acid oxidation and metabolites derived from gut bacteria metabolism of amino acids, carbohydrates, and bile acids. Elevated levels of pro-inflammatory cytokines, anti-inflammatory cytokines, and chemokines are linked to more pronounced ASD stereotypical behaviors (Ashwood et al., 2011a, 2011b). Additionally, the use of immunomodulatory treatments in ASD have experimentally shown to reduce RRBs, including cognitive and behavioral rigidity as measured by the Montefiore Einstein Rigidity Scale – Revised (MERS-R) (Hollander, Uzunova, et al., 2020).

One of the commonly proposed mechanisms of the deficits in ASD is an increased excitatory-inhibitory (E/I) ratio and imbalance between excitation and inhibition. E/I imbalance is thought to be due to abnormal GABAergic and glutamatergic neurotransmission in key brain regions, including the parietal-occipital and frontal cortical regions (Uzunova et al., 2016).

Abnormalities in E/I balance in these regions can result in seizures, in addition to behavioral changes and social dysfunction, including irritability, repetitive and disruptive behaviors, and social avoidance and withdrawal. APAP and its active metabolite AM404 exert effects on E/I imbalance and glutamate/GABA activity, and may cause ASD via this mechanism.

A common hypothesis for the etiology of ASD is aberrant excitatory-inhibitory (E/I) neurocircuitry. This imbalance is shaped by a combination of local hyperconnectivity and long-range hypoconnectivity primarily through GABA and glutaminergic pathways. These abnormalities have been localized to regions such as the hippocampus, cerebellum, amygdala, and neocortex (Nezgovorova et al., 2021; Uzunova et al., 2016). E/I imbalance may be due to increase in glutamatergic or decrease in GABAergic signaling. Cortical mini-columns involved in E/I imbalance are pathologically altered in ASD and consist of neuronal aggregations and their afferent, efferent and inter-neuronal connections, mediating the interactions of neuronal microcircuits (Casanova, 2007; Opris & Casanova, 2014; Uzunova et al., 2016). Cortical mini-columns (also known as microcolumns) are vertical columns through the cortical layers of the brain that are essential elements for cortical information processing. These structural modular arrangements of connected networks of neurons are fundamental computational units of the cerebral cortex.

ASD is proposed to be a "minicolumnopathy" with increased numbers of mini-columns and decreased mini-column width which leads to the sheath around the mini-columns being decreased due to dense packing and allowing for less inhibitory control. These aberrant neuronal connections in subependymal and subcortical regions may cause seizures, developmental delay, dyslexia, OCD and ASD (Casanova, 2007, 2008; Casanova et al., 2003; Uzunova et al., 2016). Key metabolic pathways were affected in ASD studies, such as end products of glycolysis

(lactate/pyruvate), amino acid and TCA cycle metabolism (Likhitweerawong et al., 2021; Ming et al., 2012; Needham et al., 2021; Orozco et al., 2019; Smith et al., 2020) and one carbon metabolism (Homocysteine metabolism/methionine cycling) via folic acid-folate cycle (Orozco et al., 2019). Significant metabolites derived from gut bacteria metabolism of amino acids, carbohydrates, and bile acids were altered in children with ASD (Ming et al., 2012; Orozco et al., 2019) and fatty acid oxidation (Needham et al., 2021). As mentioned above, association between lipid metabolism and ASD is supported by significant alterations of omega-3 (n-3) and omega-6 (n-6) fatty acids seen in the plasma of ASD patient including the ratio of omega-3/omega-6 PUFAs. Differentially expressed lipids in ASD include phospholipids, cholesterol esters and glycerolipids, in general shorter saturated fatty acid chain (14-18) were less abundant in ASD and elevations in PUFA side chains were seen in DAGs, and enrichment of 18:2 linolenic acid in most lipid classes (Needham et al., 2021). PUFA metabolism, resulting in production of eicosanoids, may be overactive in ASD.

Individuals with ASD have marked immune dysfunction and heightened inflammatory processes demonstrated by altered cytokine and chemokine profiles (Ashwood et al., 2011) and increased microglial activation (Goines & Ashwood, 2013; Hsiao, 2013; Masi et al., 2015; Onore et al., 2012; Vargas et al., 2005). Individuals with ASD have elevated pro-inflammatory cytokines (IL-1β, IL-6, IL-8, IL-12p40) (Ashwood et al., 2011) and IFN-γ and decreased anti-inflammatory cytokines (IL-10 and TGFβ). Increases in the pro-inflammatory cytokines are associated with more regressive autism and more pronounced stereotypical behaviors. Further, in children with ASD and asthma IL-17 is elevated following T-cell stimulation (Akintunde et al., 2015). These changes in cytokines in ASD may be developmentally regulated as they differ when measured during the neonatal period compared to later developmental periods (Abdallah et al., 2012; Abdallah, Larsen, Grove, Bonefeld-Jørgensen et al., 2013; Abdallah, Larsen, Grove, Nørgaard-Pedersen, et al., 2013;

M. L. Estes & McAllister, 2015). Seizures are frequent among children with ASD and may also have an association with immune dysfunction, inflammation and altered cytokines. Polyunsaturated fatty acid (PUFA) metabolism, resulting in production of eicosanoids, inflammatory mediators which can be stimulated by, and in turn modulate, cytokine levels, may be overactive in autism (Brigandi et al., 2015; Tamiji & Crawford, 2011; Yui et al., 2016). In addition, an imbalance in the ratio of omega-3/omega-6 PUFAs is noted in ASD.

Data from the Autism Brain Imaging Data Exchange has also shown differential associations between BMI and brain structural changes in children with ASD compared to typically developing children. BMI is negatively associated with left caudate volume (a part of the human brain involved in movement and cognitive function) and positively associated with bilateral ventral diencephalon volumes (a part of the human brain that coordinates signals to the endocrine system and cerebral cortex). These changes in subcortical volumes were also significantly associated with ASD symptom severity, as measured by the Vineland (Hwang & Hong, 2022). Proposed mechanisms for the links between obesity, ASD and symptom severity include hyperactivation of the PI3K/AKT/mTOR pathway (involved in regulating the cell cycle), insulin signaling and endocrine markers, including leptin. The PI3K/AKT/mTOR pathway affects synaptic plasticity, and an increase in mTOR is shown to reduce synaptic plasticity. Insulin is able to cross the bloodbrain barrier, and regulates synaptic activity in the cerebellum, prefrontal cortex and hippocampus, in addition to other areas. Insulin signaling in the brain is predicted to activate the PI3K/AKT/mTOR pathway. It is possible that for mothers with diabetes insulin signaling hyperactivates the fetal PI3K/AKT/mTOR pathway causing structural and signaling changes very early in development that lead to ASD (Stern, 2011).

The endocannabinoid (eCB) system has an important role in neurodevelopment (Basavarajappa et al., 2009) and is transiently activated during stressful conditions (Steiner & Wotjak, 2008). It exerts its effects through G-protein coupled (GPCR) CB₁ and CB₂ cannabinoid receptors, transient receptor potential (TRP) channels (Iannotti et al., 2014) that may modulate calcium flux (Ryan et al., 2009), the orphan G-protein-coupled receptor GPR55, the 5-HT1A receptor, the α3 and α1 glycine receptors (Devinsky et al., 2014; Li, Jones, & Persaud, 2011), and nuclear PPARs (Battista et al., 2012). CB₁ receptors are among the most widely expressed GPCRs in the brain and may occur in peripheral nerves and non-neuronal tissues. CB₂ receptors are expressed predominantly in cells of the immune system (Siniscalco et al., 2013), and may be expressed at sites of tissue damage, including within the central nervous system (CNS). eCBs are synthesized on demand and the eCB system may be modulated by ligand binding to the CB₁ and CB₂ receptors, inhibition of cellular eCB uptake or by modulating the intracellular metabolism of eCB by specific enzymes (Battista et al., 2012).

Numerous studies implicate the eCB system in ASD (Chakrabarti et al., 2015). Disruption of this system may impair social communication, social play and reciprocity (Kerr et al., 2013). Polymorphisms in the CB₁ receptor gene may adversely affect social reward processing in ASD (Chakrabarti & Baron-Cohen, 2011). The BTBR autism mouse has upregulated CB2A gene expression in the cerebellum, and treatment with an eCB reduces locomotor activity, suggesting an impact on irritability and repetitive behaviors (Onaivi et al., 2011). Children with ASD have increased CB₂ mRNA and protein levels in peripheral blood compared to healthy subjects (Siniscalco et al., 2013). Intriguingly, eCB-mediated signaling at inhibitory synapses is dysregulated in mouse models of autism-associated Neuroligin 3 mutations (Földy, Malenka, & Sudhof, 2013). In another mouse model of autism, the Fragile X knockout mouse, there is an

absence of an eCB-mediated type of synaptic plasticity (long term depression) in the ventral striatum and prefrontal cortex. Pharmacological enhancement of the eCB signaling normalizes the synaptic plasticity deficit and corrects the behavioral abnormalities, suggesting that the eCB signalosome is a molecular substrate in Fragile X syndrome (Jung et al., 2012).

eCBs also have potent anti-inflammatory and immunosuppressive properties (Devinsky et al., 2014; Jean-Gilles, Gran, & Constantinescu, 2010; Klein & Cabral, 2006; Siniscalco et al., 2014), eCBs have been identified in immune cells, such as monocytes, macrophages, basophils, lymphocytes, and dendritic cells (Cabral, Rogers, & Lichtman, 2015). Reciprocal regulation has been described between the eCBs and the immune system mediated by cytokines (Jean-Gilles, Gran, & Constantinescu, 2010). Children with ASD have immune system dysfunction including marked microglial activation (Takano, 2015), altered cytokine profiles (Masi et al., 2015) with an elevation of pro-inflammatory cytokines in the postmortem brain and peripheral blood (McDougle et al., 2015), the presence of autoantibodies directed to brain and other antigens, and an association with MHC complex haplotypes (Gesundheit et al., 2013). From these immune system changes, peripheral blood cytokines are readily measurable and quantifiable biomarkers (Rose & Ashwood, 2014). Elevated levels of the enzyme Nagalase, which is responsible for proper macrophage function (via Gc Protein-Derived Macrophage Activating Factor, GcMAF) (Bradstreet et al., 2012), and significantly upregulated CB₂ receptor mRNA in peripheral blood mononuclear cells (PBMC) have been reported in children with ASD (Siniscalco et al., 2013). Decreased serum levels of N-arachidonoylethanolamine (AEA or anandamide) and N-palmitoylethanolamine (PEA), and N-oleoylethanolamine (OEA) have been found in two case-control studies in ASD children compared with matched healthy children (Karhson et al., 2018; Aran et al., 2019). One case control study also found decreased plasma AEA, PEA and OEA levels as well as a decrease in plasma 2arachidonoylglycerol (2-AG) in ASD children (Zou et al., 2021). These alterations indicate that the eCB system is involved in ASD pathogenesis.

Treatment with GcMAF ameliorates the autistic symptoms in some children (Siniscalco et al., 2014). This may be due to effects on the gene expression of the eCB system and CB2R protein, and down-regulation of the over-activation of blood monocyte-derived macrophages. The multiple links between the eCB system and ASD suggest mechanisms and targets for potential treatments.

ASD studies show key metabolic pathways are affected, such as end products of glycolysis (lactate/pyruvate), amino acid and TCA cycle metabolism (Smith et al., 2020; Ming et al., 2012; Orozco et al., 2019; Needham et al., 2021; Likhitweerawong et al., 2021) and one carbon metabolism (Homocysteine metabolism/methionine cycling) via folic acid-folate cycle (Orozco et al., 2019). Significant metabolites derived from gut bacteria metabolism of amino acids, carbohydrates, and bile acids were altered in children with ASD (Ming et al., 2012; Orozco et al., 2019).

Oxidative stress, caused by an imbalance of prooxidative and antioxidative substances that results in the increased production of cell-damaging free radicals, is also important in the pathophysiology of ASD and related disorders. Fetuses are highly susceptible to the reactive oxygen species (ROS) produced by oxidative stress, and multiple prenatal risk factors for ASD development in offspring, including exposure to APAP, low birth weight, and preeclampsia, are also linked to oxidative stress. This suggests that prenatal oxidative stress directly impacts fetal neurodevelopment, and/or indirectly acts through other mechanisms, such as inflammation or placenta dysfunction (Carey et al., 2022).

Biomarkers of oxidative stress include, but are not limited to, 8-oxo-deoxy-guanine (8-OHdG), glutathione (GSH), glutathione disulfide (GSSG), GSH:GSSG ratio, 3-nitrotyrosine, and

prostaglandin F2alpha (PGF2a), free-8-isoprostane-prostaglandin-F2alpha. In a study examining oxidative stress biomarkers in pregnant women who already had a child with ASD, and in their offspring at 36 months (EARLI study), modest increases were observed in ASD-related traits with increasing GSH:GSSG ratio, a measure of antioxidant balance, for those in the middle percentiles of Social Responsiveness Scale (SRS, measure of social communication deficits) (Carey et al., 2022). Increasing levels of the GSH:GSSG ratio indicate less oxidative stress and increased antioxidant balance. There was also evidence supporting an inverse association between risk of ASD or non-typical development, with greater antioxidant balance (higher GSH:GSS ratio), which suggests the association between ASD symptoms and oxidative stress exists across a spectrum, and that increased oxidative balance prenatally, results in reductions in ASD or non-typically developing symptoms in offspring.

The presence of oxidative stress biomarkers during pregnancy and increased ASD risk in offspring is also supported by a study examining the associations between multiple urinary biomarkers of oxidative stress in the 3rd trimester of pregnancy and behavioral development in children (Infant Development and the Environmental Study, TIDES; Rommel et al., 2020). These researchers found a 2.58% increase in child SRS T-scores at age 4-5 associated with an IQR increase in levels of free 8-isoprostaneprostaglandin-F2alpha in their mother's urine samples in the third trimester. This association was modified by level of maternal education. Scores on the BASC-2 externalizing problems subscale at age 4 years were also positively associated with third trimester urinary concentrations of PGF2alpha, and were also modulated by level of maternal education. The BASC Behavioral Symptoms Index in children at age 4, was also positively associated with third trimester urinary concentrations of 8-iso-PGF2alpha and PGF2alpha. These results suggest that oxidative stress during the third trimester is associated with social impairments

and behavioral problems in children, that correlate with symptoms of ASD, ADHD and related disorders. Of note, while the EARLI study is one of pregnant mothers who already have a child with ASD, the TIDES study was completed in the general population. As pregnant women are already more susceptible to oxidative stress, and are found to have lower levels of glutathione (Balasubramanian & Birundha, 2019), the primary intracellular ROS antioxidant and detoxification mechanism in the body, any additional environmental or genetic insult may exacerbate this resulting in aberrant fetal neurodevelopment.

Biomarkers of oxidative stress have also been found in children with ASD, suggesting that in utero exposure to oxidative stress causes pathophysiological changes that persist across the child's lifespan. A study of plasma metabolites in the methionine cycle and transsulfuration pathway in 20 autistic children and 33 neurotypical controls, showed that children with autism had significantly lower baseline plasma concentrations of methionine, SAM, homocysteine, cysteine and total glutathione, and higher concentrations of SAH, adenosine and the oxidized disulfide form of glutathione (GSSG) (James et al. 2004). These results were replicated in a larger study of 80 children with ASD compared to those who are typically developing (n = 73), children with ASD had significantly decreased levels of methionine, S-adenosylmethionine (SAM), SAM/SAH ratio, cysteine, total glutathione, free reduced glutathione, and GSH:GSSG ratio, and had increased levels of S-adenosylhomocysteine (SAH), cystathionine and the oxidized disulfide form of glutathione (GSSG) (James et al., 2006). These key metabolic abnormalities indicate significant impairments of antioxidant capacity, redox homeostasis, and methylation capacity, and that these individuals with ASD were currently experiencing oxidative stress.

The autism Integrated Metabolic and Genomic Endeavor (IMAGE) study is a case-control study with over 68 case children, 40 unaffected siblings, and 54 age-matched unaffected control

children, examining the role of metabolic and genomic factors in the pathophysiology of ASD and symptom severity (Melnyk et al., 2012). Similar to the results for the previous two studies discussed, children with autism were found to have significantly decreased methionine and SAM, and significantly increased SAH and adenosine, compared to their paired unaffected siblings. Total cysteine levels and the GSH:GSSH ratio were also decreased in children with autism compared to their unaffected siblings indicating increased oxidative stress. On the majority of the above markers, unaffected siblings were not different from unrelated controls. The authors discuss the important role of gene-environmental model and how the epigenetic alterations and oxidative DNA damage observed in the children with autism in this study, is consistent with the Latent Early-life Associated Regulation (LEARn) model. The LEARn model proposes that environmental and genetic risk factors operate through oxidative stress and alterations in DNA methylation in susceptible genes which ultimately results in altered gene expression. Epigenetic and redox alterations are seen as dynamic adaptive responses to environmental stressors. Studies of frozen brain tissue from individuals with autism and unaffected controls confirms the above results (Rose et al., 2012). Biomarkers of oxidative stress, including significantly decreased GSH and GSH/GSSG ratio and significantly increased 3-nitrotyrosine (3-NT) and 8-oxo-deoxyguanosine (8oxo-DG) levels, were found in the cerebellum and temporal cortex of brains of individuals with autism compared to controls. These results continue to support the role of increased oxidative stress in ASD. Biomarkers of oxidative stress are noted to continue into adulthood for those with ASD and are correlated with autism symptom severity as measured by the Autism Quotient score (Thorsen et al., 2022). In a study of adults with ASD compared to age- and sex-matched controls, individuals with ASD had higher levels of the antioxidant superoxide dismutase 1 (SOD1) which was correlated with higher scores on the Autism Quotient.

B.7. Pharmacological and Psychological Treatments

To date, no medication has been approved to treat the "core" symptoms of ASD. Instead, pharmacologic treatment aims to manage the comorbid behavioral symptomatology that is often associated with ASD including irritability, hyperactivity, aggression, impulsivity, anxiety, and affective symptoms. Medications are being developed for individuals with ASD that specifically target the mechanisms thought to be involved in the pathophysiology of the core symptom domain of social communication and repetitive behaviors (i.e., oxytocin and vasopressin-related treatments) (Hollander & Uzunova, 2017), More importantly, however, various psychological treatment options are available for individuals with ASD. The most studied and empirically supported behavioral treatment is Applied Behavioral Analysis (ABA), which utilizes discrete trials to teach simple skills with a gradual progression to more complex skills as the individual's behavior improves (Roane et al., 2016). Speech therapy is particularly important for those with ASD who are nonverbal, as it can be used to teach them alternate modes of communication. In addition, other forms of therapy such as Cognitive Behavior Therapy (CBT) and Dialectical Behavioral Therapy (DBT) may be recommended. Because those with ASD are less likely to respond to CBT, alternative ways of presenting the intervention have been created to better accommodate the symptom presentation of those with ASD. DBT is a comprehensive, evidencebased form of psychotherapy that evolved from CBT as a way to help individuals with severe emotion dysregulation. Mindfulness therapies have also been used with individuals with ASD across the lifespan, with modifications made to address common inattention, self-awareness difficulties and abstraction limitations present in the population (Beck et al., 2020). Occupational therapy is a commonly prescribed treatment for children with ASD. Residential treatment and group homes may be considered when the individual presents with severe behavioral symptoms that cannot be addressed in outpatient settings.

C. Attention-Deficit Hyperactivity Disorder

ADHD is a chronic neurodevelopmental disorder characterized by persistent patterns of inattention and/or hyperactivity and impulsivity that are disruptive and result in functional impairment in multiple settings. Behaviors must be present for at least 6 months, and must have started before age 12. The symptoms must be present across more than one setting (i.e., home, work, or school), and these symptoms must result in academic, social, or occupational impairment. ADHD symptoms may be more difficult to detect in females, due to more predominant inattention symptoms in early childhood that do not cause as significant of functional impairment until early adolescence. When diagnosing individuals aged 17 and older, fewer symptoms are required.

ADHD is the most frequently occurring and researched psychiatric disorder of childhood and accounts for the majority of referrals to child and adolescent psychiatry services. In the United States, 6 million (9.8%) children aged 3 to 17 years are estimated to live with ADHD, according to a national survey of parents. Boys (13%) are more likely to be diagnosed with ADHD than girls (6%). Approximately 6 in 10 children with ADHD had at least one other mental, emotional or behavioral disorder, with half also diagnosed with a behavior or conduct problem, and about 3 in 10 diagnosed with comorbid anxiety. Other common comorbid disorders are ASD, depression, and Tourette syndrome. ADHD persists into adulthood in many individuals, and the burden of the disease in adults has been well described. Meta-analyses estimate the prevalence of ADHD in adults aged 19 to 45 years to be between 2% and 5% (Simon et al., 2009), with approximately 15% of patients persisting with full diagnostic criteria in adulthood and 40% to 60% classified as partial remitters (Posner et al., 2020).

Point prevalence rates for ADHD are similar across the globe, including North America, Europe, Oceania, South America, Asia, Africa, and the Middle East, Community samples of children and adolescents from 35 countries in six continents show a prevalence rate of ADHD ranging from 5% to 29% (Polanczyk et al., 2014). Over the past two decades, rates of children diagnosed with ADHD have increased significantly from 7% to 10.2% (Ji, 2018). As with ASD, there have been statistically significant increases in the proportion of children ages 5 to 17 years reported to have been diagnosed with ASD and/or ADHD between 1997 and 2017 (U.S. EPA, "Health – Neurodevelopmental Disorders," Overviews and Factsheets, May 29, 2015), Prevalence rates do not differ between North America and Europe, which supports the view that ADHD is not a construct of North American culture. Within North America, the National Survey of Children's Health (NSCH) regularly completes population-based surveys examining prevalence rates of multiple neurodevelopmental, mental health, and medical disorders in addition to other aspects of children's health. Through this study, the percentage of children with a lifetime diagnosis of ADHD increased from 7.8% to 9.5% from 2003 to 2007, a 21.8% increase. From 2003 to 2011, NSCH determined that the number of children aged 3 to 17 ever diagnosed with ADHD in the US steadily increased from 4.4 million to 6.4 million. Prevalence estimates from 2016 to 2019 show that 6 million children in the US aged 3 to 17 were ever diagnosed with ADHD.

Additional studies of ADHD medication usage have demonstrated that 66.3% of children and adolescents with a current ADHD diagnosis were taking medication for the disorder, which represented 4.8% of all children aged 4 to 17 years. In California, an analysis of medical records from 2001 to 2010 showed a relative increase of 24% in the incidence of physician-diagnosed ADHD in children aged 5 to 11 (Getahun et al., 2013). These numbers are consistent with other studies that use administrative data to calculate prevalence rates in the USA, UK, and Canada from

1990s through 2000s (Bitsko et al., 2022; Cree et al., 2023; Danielson et al., 2018; G. Polanczyk et al., 2007; G. V. Polanczyk et al., 2014; Posner et al., 2020; Visser et al., 2016).

C.1. DSM-IV and DSM-5 Definitions and Diagnostic Criteria

The course of ADHD varies between individuals, and four developmental trajectories have been identified, including (1) early onset (preschool, ages 3 to 5), (2) middle childhood onset with a persistent course (ages 6 to 14), (3) middle childhood onset with adolescent offset (6 to 14 years), and (4) adolescent or adult onset (16 years and older). Within the DSM-5, the newer concept of partial remission was introduced, which acknowledges that some children diagnosed with ADHD may not have symptoms that functionally impact their activities of daily living beyond age 18. In the Longitudinal Assessment of Manic Systems (LAMS) study, 431 children with childhood-onset ADHD were monitored for eight years, with about 30% demonstrated stable full remission at the end of their participation and more than half continuing to meet ADHD criteria (Van Meter et al., 2023).

Through periodic review and reformulation, the specific criteria for children and adults to receive an ADHD diagnosis has changed to fit with growing knowledge and larger working hypotheses about the structure and nature of the disorder. In DSM-5, the changes made to the diagnostic criteria included modifying the required age of symptom onset from before age 7 (DSM-IV criteria) to before age 12, so that diagnoses could be made more effectively for adults; and changing the term "subtype" to "presentation" in an effort to recognize that symptom profiles can change across the lifespan. The complete DSM-5 and DSM-IV diagnostic criteria for ADHD are excerpted in **Appendix 2**.

These diagnostic changes have also been made in the ICD-11, where ADHD has been moved from the disruptive behavior domain to the neurodevelopmental disorder domain,

highlighting it as a disorder of the nervous system caused by both genetic and environmental effects prenatally. Additional changes to the ICD in its latest version included changing the diagnostic label from "hyperkinetic disorder" to "ADHD," including both the hyperactive-impulsive and inattention presentations, making the diagnosis uniform across international bodies.

As discussed above, ADHD is a chronic neurodevelopmental disorder that typically has onset in early childhood, although onset later in life is possible as individuals are confronted with more cognitive demands and situations that tax executive functioning resources. Hyperactivity symptoms usually begin at age 3 or 4, with combined symptoms of inattention and hyperactivity usually presenting from ages 5 to 8. Symptoms are progressive and constant.

Under the DSM-IV-TR, ADHD was classified as a disruptive behavior disorder (Doernberg & Hollander, 2016). With the introduction of the DSM-5, however, ADHD was classified as a neurodevelopmental disorder. The 18-symptom diagnosis criteria for ADHD in the DSM-IV remained nearly the same in the DSM-5 (Doernberg & Hollander, 2016). Significantly, the DSM-5 chapter for Neurodevelopmental Disorders allows for comorbid diagnosis of both ASD and ADHD, which was not previously allowed in the DSM-IV.

ADHD may also be referred to as Hyperkinetic Disorder (HKD) in some countries, and the terms may be used interchangeably. Both ADHD and HKD refer to a combination of inattention, hyperactive, and impulsive behavior in children. HKD is the term listed in the ICD-10. The complete list of elements of the ICD-10 are excerpted in **Appendix 2.**

Differences in diagnostic criteria between the DSM-5 and ICD-10 can be seen in the table below. The overall consensus diagnostically is that HKD is a subset of ADHD, which identifies a refined phenotype (Swanson et al., 1998).

	DSM-5	ICD-10
Name	ADHD	Hyperkinetic disorder
Onset	Some symptoms before age 12	Some symptoms before age 6
Symptom criteria for children	ADHD combined: 6 of 9 symptoms of inattention and 6 of 9 symptoms of hyperactivity/impulsivity ADHD predominantly inattentive: 6 of 9 symptoms of inattention ADHD predominantly hyperactive/impulsive: 6 of 9 symptoms of hyperactivity/impulsivity	Must have a combination of impaired attention AND hyperactivity The only subtype is hyperkinetic conduct disorder for those who meet criteria for both disorders
Symptom criteria for persons aged >_ 17	ADHD combined: 5 of 9 symptoms of inattention and 5 of 9 symptoms of hyperactivity/impulsivity ADHD predominantly inattentive: 5 of 9 symptoms of inattention ADHD predominantly hyperactive/impulsive: 5 of 9 symptoms of hyperactivity/impulsivity	Must have a combination of impaired attention and hyperactivity
Settings	Several symptoms present in ≥ 2 settings	Full syndrome in ≥ 2 settings and observed by clinician
Duration	≥ 6 months	≥6 months
Impairment	Interference with social, academic, or occupational functioning; includes severity specifiers: mild, moderate, severe	Clinically significant distress or impairment in social, academic, or occupational functioning.

C.2. Sex Differences in ADHD Diagnoses

Overall, ADHD is more prevalent in males, at ratios of approximately 3:1, although some studies have reported smaller male to female ratios (2.28:1) due to possible underdiagnosing of ADHD cases in females (Ramtekkar et al., 2010). This disorder typically emerges during childhood or early adolescence (Faraone et al., 2021). A comprehensive meta-analysis examining parent ratings of symptoms in 29 studies with over 42,000 participants, and teacher ratings in 24 studies with over 56,000 participants, revealed an approximate two-to-one male-to-female ratio among youth (Willcutt, 2012).

However, research has increasingly shown that ADHD is not predominantly a disorder affecting males, although boys are more commonly diagnosed with ADHD compared to girls, with

ratios ranging from 2:1 to 9:1 depending on the subtype and setting (Rucklidge, 2010). It is worth noting that in clinical settings, boys are more likely to be referred for evaluation (Rucklidge, 2010). However, studies conducted with adult populations have revealed a higher prevalence of ADHD in women than in men in certain psychiatric outpatient services. Estimates suggest that globally, approximately 32 million females have ADHD, highlighting the significance of addressing ADHD in females as a major public health concern (Rucklidge, 2010).

It is important to recognize that there is still a tendency for referral bias, leading to underidentification of ADHD in females, especially among younger individuals (Rucklidge, 2010). Moreover, recent research has questioned previous assumptions that females with ADHD are less affected by the disorder compared to males (Rucklidge, 2010). Current studies have provided compelling evidence that females with ADHD face significant challenges across multiple aspects of functioning, including academics, cognition, psychosocial well-being, and mental health. These findings demonstrate that females with ADHD experience similar levels of difficulties as males with ADHD, highlighting the substantial impact of the condition on their overall functioning (Rucklidge, 2010).

Numerous studies have consistently shown that girls diagnosed with ADHD are more commonly associated with the predominantly inattentive type, in contrast to boys (Biederman et al., 2005; Weiss, et al. 2003). Additionally, parents and teachers tend to perceive boys with ADHD as more hyperactive, while girls are often seen as more inattentive (Papageorgiou, et al., 2008).

Boys diagnosed with ADHD tend to exhibit higher rates of comorbid externalizing problems, while girls with ADHD, particularly during adolescence, tend to have higher rates of comorbid internalizing problems such as depression and anxiety (Gerschon, 2002). However, it is

important to note that studies conducted on non-referred samples do not find gender differences in the rates of coexisting psychiatric disorders among children with ADHD.

Mahendiran et al. investigated potential sex differences with age in social adaptive function across ASD and ADHD (Mahendiran et al., 2019). The objective of the study was to investigate potential variations in social adaptive functioning across different ages and between males and females with ASD, ADHD, and typically developing individuals. In the ADHD group, significant findings were identified. Additionally, sex differences and interactions between age and diagnosis were observed in the social and leisure domains between ASD and ADHD. Females with ADHD consistently exhibited higher scores in social skills compared to males across all age groups. Similar patterns of sex differences in the social domains were observed between the ADHD group and the typically developing controls. Notably, differences in social and communication skills were observed between ASD, ADHD, and typically developing individuals.

To maximize the efficacy of psychosocial and medical treatments for individuals with ADHD, it is crucial to consider the varying impact of the disorder on different genders across various domains of functioning. Understanding these gender-specific effects is vital in tailoring interventions to address the unique needs of both males and females affected by ADHD.

C.3. Associated Features and Co-Morbid Psychiatric and Medical Disorders

ADHD often co-occurs with other psychiatric disorders, including depression, bipolar disorder, ASD, anxiety disorders, oppositional defiant disorder, conduct disorder, eating disorder, and substance use disorders. The presence of these co-morbid disorders does not rule out a diagnosis of ADHD. Approximately 6 in 10 children (64%) with ADHD are diagnosed with at least one other mental, emotional, or behavioral disorder. Individuals with ADHD and comorbid depression are shown to have greater functional impairment, including longer and more severe

depressive episodes and higher rates of suicidality, when compared to those with only ADHD, or only depression (Biederman et al., 2008; Chronis-Tuscano et al., 2010).

Individuals with ADHD are also at a higher risk for certain medical disorders, including obesity, asthma, diabetes mellitus, and somatic disorders. In particular, researchers found that individuals with ADHD had a threefold greater risk of obesity compared to their family members without ADHD (Chen et al., 2018). Studies show that individuals with asthma or who were born to asthmatic mothers were between 40% to 45% more likely to have ADHD (Cortese et al., 2018; Liu et al., 2019). ADHD was 40% more likely to be diagnosed among children with type 1 diabetes (Kapellen et al., 2016), and about three times more likely to develop type 2 diabetes (Chen et al., 2018).

Individuals with ADHD have a greater sleep onset latency and lower sleep efficiency (Lugo et al., 2020). Individuals with ADHD also present with greater rates of autoimmune and inflammation disorders, such as psoriasis (Hegvik et al., 2018). There is also over twice the prevalence of ulcerative colitis, autoimmune thyroid disease, and ankylosing spondylitis in those with ADHD (Chen et al., 2017). Children with an autoimmune disease were 24% more likely to develop ADHD, and those born to mothers with autoimmune disease had a 12% greater chance of developing ADHD (Nielsen et al., 2017). Celiac patients are also shown to have a 29% increased risk of ADHD (Lebwohl et al., 2020). Individuals with epilepsy have between a 2- and 4-fold increased risk of ADHD (Bertelsen et al., 2016; Chou et al., 2013; Brikell et al., 2018).

C.4. Imaging and Anatomical Differences

Meta-analyses of task-based functional MRI (fMRI) studies have identified abnormalities in the function of many neural networks, including those related to attention and executive function. Regions of inhibitory control are frequently under-activated in those with ADHD

compared to neurotypical controls, particularly the right inferior frontal cortex, basal ganglia, and supplementary motor area (Hart et al., 2013; Lukito et al., 2020, Norman et al., 2016).

Structural MRIs (sMRI) have also been used to examine brain structure, with metaanalyses confirming alterations in the limbic system and basal ganglia. Familial risk of ADHD has also been linked to reductions in total grey matter and abnormal basal ganglia volumes. Grey and white matter abnormalities are shown to persist into adulthood for some individuals with ADHD.

Individuals with ADHD also appear to have smaller hippocampus volume compared to those with OCD; and smaller intracranial volume compared to individuals with ASD or OCD (Boedhoe et al., 2020). A study of over 4,000 participants using sMRI showed children with ADHD had slightly reduced total cortical surface area, smaller frontal, cingulate, and temporal regions, and reduced volumes in the basal ganglia, amygdala, hippocampus and intracranially (Hoogman et al., 2017; Hoogman et al., 2019). Examination of the brains of those with ADHD using diffusion MRIs has shown widespread alterations in white matter microstructure, particularly in the right anterior corona radiata, right forceps minor, left cerebellum, and bilateral internal capsule. The most consistent white matter differences between those with and without ADHD are in the splenium of the corpus collosum, and can extend to the right cingulum, right sagittal stratum and left tapetum. This suggests there are problems with the posterior parieto-temporal attention regions and long-range fronto-posterior association tracts that connect the two hemispheres. Both of these regions are involved in attention and perception (Chen et al., 2016).

There is also evidence for abnormal interactions in large-scale brain networks, with maturational delay during cortical development in utero. Although research into this area is still in the early stages, there is evidence that children with ADHD present with hyperconnectivity between the dorsal attention network (DAN) and regions of the default mode network (DMN).

There is also evidence of hyperconnectivity between the DMN and regions involved in the somatosensory, visual and auditory cortices (Lin et al., 2021). While this study indicated the presence of hyperconnectivity, others have suggested there is decreased functioning connectivity in some regions of the DMN and DAN, and more research is needed to better understand how these networks are impacted in ADHD. Electrophysiological studies have shown some evidence that children with ADHD have small-to-moderate reductions in mismatch negativity amplitude compared to neurotypical controls, which could indicate issues with auditory sensory memory and involuntary attention switching (Cheng et al., 2016).

C.5. Neurobiological Markers

There is no known diagnostic neurobiological marker for ADHD. Animal models have been helpful in understanding the role of dopaminergic, noradrenergic and serotonergic neurotransmission in the presentation of inattention, motor overactivity, and impulsivity symptoms. Examination of cerebral networks responsible for motor response inhibition, one of the most comprised cognitive functions in ADHD, have not found any way to systematically use activity in these regions to identify those with ADHD (Massat et al., 2018). Response inhibition is the ability to inhibit the initiation or the execution of inappropriate but prepotent/ongoing responses. A small study comparing boys with ADHD combined type and those who are typically developing, used fMRI data from four visuospatial working memory tasks to classify ADHD with a 92.5% accuracy rate (Hammer et al., 2015). This would need to be replicated in larger samples in order to classify it as a neurobiological marker that could be used in diagnosis. Eye vergence, the movement of both eyes in opposite directions to assist in depth perception, has also shown some evidence as a potential neurobiological marker for ADHD. During attention tasks, eye vergence has been used to differentiate ADHD from controls with a 92% accuracy in children

(Varela Casal et al., 2018), and with 79% accuracy in adults (Jiménez et al., 2021). Additionally, meta-analyses demonstrate that abnormal cortisol and inflammatory biomarker levels could be used as neurobiological markers of ADHD. Morning cortisol levels are lower in children with ADHD compared to those who are typically developing, and the inflammatory biomarker Tumor Necrosis Factor – alpha (TNF-alpha) is also lower in those with ADHD compared to neurotypicals (Chang et al., 2021). Further research needs to be completed on all of the above before any are added to the standard protocol to screen for or confirm ADHD.

C.6. Genetic Factors

ADHD is a complex disorder with no single risk factor or cause. Many environmental and genetic factors contribute to risk, with a multifactorial pattern of inheritance. The relative risk of ADHD in first degree relatives of probands is between 5 and 9, and heritability estimates range from 71% to 90% in twin studies across the globe. This magnitude is similar to that of ASD and schizophrenia (Thapar & Cooper, 2016). Siblings and parents of ADHD patients are two- to eightfold more affected by ADHD than relatives of healthy individuals. Offspring of parents with ADHD are also observed to have children with more severe forms of ADHD.

Overall, ADHD is more prevalent in males, at ratios of approximately 3:1, although some studies have reported smaller male to female ratios (2.28:1) due to possible underdiagnosing of ADHD cases in females (Ramtekkar et al., 2010).

ADHD is thought to have a polygenic cause, meaning that many genetic variants, each with a small effect, combine together to increase the risk for the disorder. This also means that genetic risk factors of ADHD can also influence lower levels of ADHD symptoms in the general population, that might be below threshold for a full ADHD diagnosis (Demontis et al., 2019; Taylor et al., 2019).

The alteration of genes involved in dopamine functioning have been the most researched in relation to ADHD and hyperkinetic symptoms. The most robust data for gene associations exists for a dopamine transporter gene responsible for dopamine reuptake at the site of neuronal communication and those for dopamine receptors. Studies of variable number tandem repeats (VNTR) in the 3' untranslated region of the dopamine transporter gene have also been shown to predispose individuals to ADHD when combined with prenatal risk factors and environmental insults (Thapar et al., 2012).

Correlations have also been found between risk of ADHD and genes involved in immunological pathways (Drtilkova et al., 2008). Studies have also been completed to explore possible rare genetic variants of ADHD using copy number variants (CNVs) analysis. CNVs were found to contribute to only 0.2% of ADHD heritability, and most that were associated with ADHD were also associated with other psychiatric disorders, including autism and schizophrenia. This suggests a possible overlap in the mechanisms behind these disorders.

MicroRNAs are short, noncoding RNAs responsible for gene regulation after the transcriptional stage. In ADHD, they have been shown to play a role in the regulation of ADHD-associated genes.

It is important to note that although there are several genes and genetic mechanisms involved in ADHD pathology, the results are not always consistent, and much more research needs to be completed.

C.7. Environmental Factors

Epigenetic processes are crucial for normal cellular development and differentiation. They allow for the regulation of gene function through non-mutagenic mechanisms. Epigenetic modification during key developmental periods, prenatally and neonatally, have shown significant

associations with environmental insults present during or around these time periods (Mill & Petronis, 2008). Exposure to all environmental insults identified as risk factors for ADHD are known to occur during these time periods.

Neurons are more prone to epigenetic changes when exposed to an environmental insult when they are undergoing mitosis, or cell proliferation, as they are during key stages of in utero development. Possible epigenetic changes due to exposure to environmental insults, includes histone acetylation, methylation, and phosphorylation; cytosine methylation in CpG islands that can lead to the silencing of a gene and the compaction of chromatin; and RNA-mediated modifications. Changes in methylation patterns have shown significant associations with the severity of ADHD behaviors.

In utero risk-factors associated with ADHD include prenatal exposure to nicotine, alcohol and recreational drugs, in addition to pre- and neo-natal exposure to toxins. These toxins and insults include, but are not limited to, APAP, lead, valproate (Christensen et al., 2019), glucocorticoids, phthalate metabolites, and organophosphates.

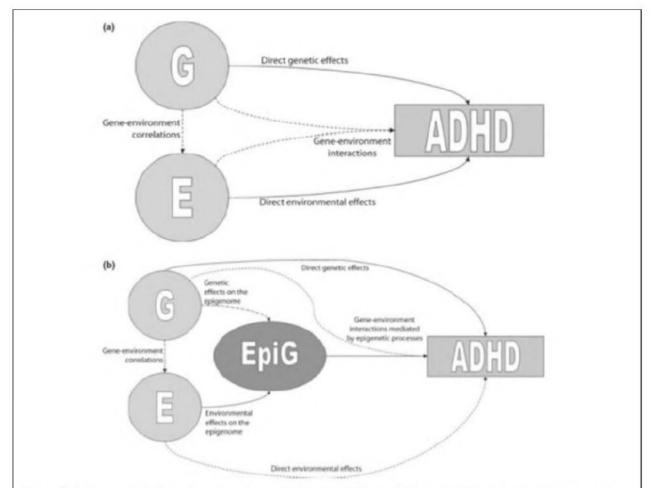


Figure 1 Incorporating epigenetic factors into aetiological models of ADHD. a) Traditional aetiological approaches see susceptibility only in terms of genetic and environmental factors. These factors are generally studied independently, but there is increasing emphasis on gene-environment interactions, whereby the phenotypic effect of genotype is mediated by the environment. b) The epigenetic theory of complex disease includes a third set of aetiological factors, namely those that impact upon the epigenome. Epigenetic dysfunction, mediated via processes such as DNA methylation and histone modifications, may act directly but are also likely to interact with both genetic and environmental factors. Increasing evidence suggests that the phenotypic effects of environmental factors, especially during key developmental periods, may be mediated by epigenetic processes.

(Mill and Petronis, 2008).

An umbrella review of meta-analyses (J. H. Kim et al., 2020) that systematically and quantitatively collected and assessed the hierarchy of evidence for potential environmental risk factors of ADHD found nine associations with high credibility. Five of those risk factors were graded as Class I (convincing evidence): maternal APAP exposure during pregnancy, childhood eczema, hypertensive disorder during pregnancy, preeclampsia, and maternal metabolic syndrome. The remaining four risk factors were regarded as Class II (highly suggestive evidence): maternal

smoking during pregnancy, maternal pre-pregnancy overweight, childhood asthma, and serum vitamin D levels. Maternal APAP exposure during pregnancy and maternal metabolic syndrome are transdiagnostic risk factors, as they were the most robust environmental risk factors for both ADHD and ASD. The largest overall indicator of an environmental insult prenatally is low birth weight, which is also one of the strongest environmental predictors of ADHD. Low birth weight is an early signal of a disruption to the in utero environment, that will have most likely impacted in utero brain development and will lead to symptoms of a neurodevelopmental disorder, such as ADHD or ASD (J. H. Kim et al., 2020; J. Y. Kim et al., 2019). Additional environmental correlates of ADHD during pregnancy and birth include the presence of maternal stress, maternal hypertension, preeclampsia, maternal obesity, maternal infection, and markers of adversity, including poverty and low socioeconomic status. These environmental insults significantly impact the prenatal environment in part due to mediation by epigenetic processes.

The association between this altered prenatal environment and ADHD has been proven in both human epidemiological studies and animal studies (Mill & Petronis, 2008). Some evidence suggests that hyperactive-impulsive symptoms are more likely due to biological risk factors, while inattentive symptoms are more influenced by psychosocial risk factors (Freitag et al., 2012). Some researchers split prenatal risk factors into three categories: chemical exposure during pregnancy, pregnancy or birth complications, and maternal health status. Chemical exposure during pregnancy includes exposure to maternal smoking, exposure to alcohol, polyunsaturated omega-3 fatty acid deficiency, exposure to polychlorinated biphenyls, exposure to APAP, exposure to valproic acid, lead exposure, and pesticide exposure. Pregnancy or birth complications include maternal age, prematurity, low birth weight, and gestational problems. Maternal health status includes maternal

obesity and maternal stress, and possibly maternal anemia during early pregnancy (Faraone et al., 2021; Kian et al., 2022).

C.8. Major Hypotheses on Pathophysiology

Current models of ADHD suggest the main pathophysiological processes involve dopaminergic and noradrenergic neurotransmission impairments, in addition to reduced brain function and volume in key brain areas involved in cognitive processing, attention, motor planning and processing speed, including the prefrontal cortex, caudate and cerebellum. Individuals with ADHD have reduced neural activity and smaller volumes in these areas, in addition to slower maturation of the prefrontal cortex. The prefrontal cortex, caudate and cerebellum are interconnected by a network of neurons, and together regulate attention, thoughts, emotions, behaviors and actions. Network activity between these areas is mostly maintained by dopamine and norepinephrine. Deficits in prefrontal and associated circuit dopaminergic and noradrenergic functioning were initially considered as major aspects of ADHD's pathophysiology, because of the effects of stimulants, which increase synaptic availability of dopamine and norepinephrine, in improving symptoms.

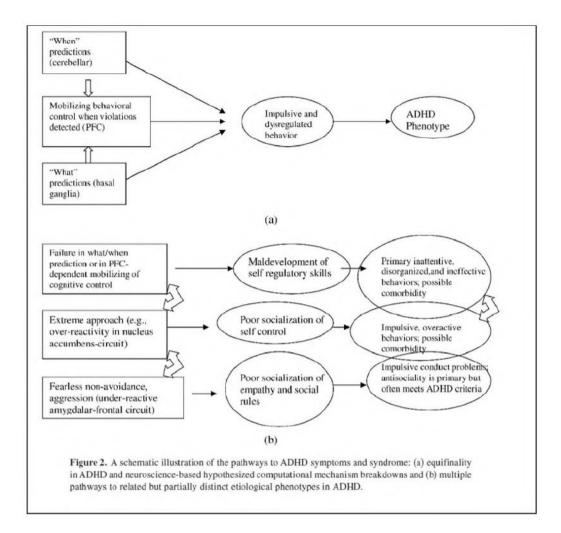
The role of these neurotransmitters has since been further supported by animal model, electrophysiological, and neuroimaging studies. Lesions in dopamine pathways create symptoms of ADHD in animal models. Additionally, individuals with ADHD have alterations in dopamine receptor density in several brain regions compared to neurotypical controls. Further supporting the role of dopaminergic pathways in ADHD pathophysiology are polymorphisms of genes that encode for dopamine receptors (DRD4, DRD 5, DAT1). There is conflict in the literature about the functionality of the dopaminergic and noradrenergic systems in ADHD, with some research positing that these systems are hyperactive in ADHD, and others stating they are

hypoactive/underactive. Recently, these hypotheses have been tied together with the knowledge that dopamine and norepinephrine exhibit inverted U-shaped dose-response curves, where either extreme is problematic. Each area of the brain may access their own supplies of dopamine and norepinephrine, with different ratios available/required for optimal functioning, and any disruption in the DA/NE availability resulting in ADHD symptoms (Sharma and Couture, 2014; Biederman & Faraone, 2005; Purper-Ouakil et al., 2011).

Three related neural circuits are proposed to be involved in the complex behavioral and cognitive symptom profile of ADHD, (1) frontostriatal circuitry; (2) frontocerebellar circuitry; and (3) frontoamygdala circuitry. Frontostriatal and frontocerebellar circuitry are both involved in cognitive control, have dopamine as a critical neuromodulator, and receive noradrenergic projections. Additionally, the cerebellum and basal ganglia both project to the prefrontal cortex via the thalamus. The inhibitory neurotransmitter GABA is primary in the basal ganglia and cerebellum, while the excitatory neurotransmitter glutamate is primary in the prefrontal cortex and the thalamus. Frontostriatal circuitry is key in detecting unpredicted rewarding or novel events, while the frontocerebellar circuitry is responsible for alerting, monitoring and detecting violations in the timing of events. Together, these systems work to monitor the environment and alter behavior in the appropriate context, learning from environmental inputs over the course of child development. They provide neural mechanisms for learning about structure in the environment, and detecting violations in these environmental predictions, which are then integrated with goals represented prefrontally in working memory. Overall, these circuits offer top-down control of behavior, and the ability to alter behavior in response to contextual changes. In the case of a child with ADHD, who is starting off with frontostriatal and frontocerebellar deficits, learning how to

accurately predict what will happen in a given setting, and adapt behaviors to fit the appropriate context will take longer than in a neurotypical child.

For example, a child with ADHD is not able to identify temporally-linked expected events (i.e., sound of a bell means sit down and work), and without knowledge of this temporal association, they are unable to detect when they are violating the norms of the expected event (i.e., continuing to talk after the bell rings), and finally, their lack of inhibitory control prevents them from adjusting their behaviors in a timely manner to fit the expected norm (i.e., stop talking and pay attention to the teacher). Thus, even if the child knows the correct behavior in certain situations, the maladaptive behavior continues due to slower processing, and lack of cognitive and inhibitory control. They would also exhibit poor sustained attention to multistep or complex tasks, slow response in contexts that require a rapid decision, difficulty set-shifting, and inefficient responses to changing learning or reward contexts (Nigg & Casey, 2005). Just as in ASD, this involves disruption of the excitatory/inhibitory balance in the brain, as GABAergic, inhibitory projections would be responsible for interrupting the ongoing behavior when needed, and shifting attention to another task; while glutamatergic, excitatory projections, are involved in maintaining relevant information in the working memory (prefrontal cortex). The third important circuit to ADHD pathophysiology in the frontoamygdala circuitry, which is important for affect regulation, motivation and reactive responses. This circuit is key to the emotional dysregulation observed in those with ADHD, including challenges regulating mood, affect and anger, and dysfunctional approach (positive emotional valence/expectation of reward) and avoidance (negative emotional valence/expectation of punishment) processes. This subsequently results in the impulsive and hyperactive symptoms of ADHD.



(Nigg and Casey, 2005).

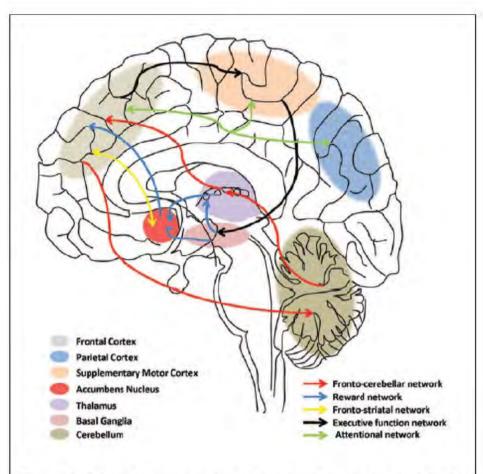


Figure 1. Schematic representation of functional circuits involved in the pathophysiology of ADHD. Here are summarized the attentional network (green), the fronto-striatal network (yellow), the executive function network (black), the fronto-cerebellar network (red), and the reward network (blue).

(Purper-Ouakil et al., 2011).

In sum, while impairments in prefrontal-striatal circuits result in the inattention and executive functioning deficits observed in ADHD, hyperactivity and impulsivity have been linked to the frontal-limbic system, and reward response and motivation dysfunction. This is also often described as the dual-pathway model of ADHD, as it defines both the cognitive and motivational deficits of ADHD and their respective pathways (Shen et al., 2020), and it is supported by neuroanatomical and neurophysiological studies (Drechsler et al., 2020).

Neuroinflammation may also play a role in the pathophysiology of ADHD (Dunn et al., 2019), as it does for many neurodevelopmental disorders, due to it causing glial activation, increased oxidative stress, neurotransmitter dysfunction, and abnormal neuronal development. Many of the early environmental risk factors for ADHD are also known to increase the inflammatory profile of the in utero environment. This is supported by maternal immune activation (MIA) animal models, in which offspring with aberrant behaviors are born to mothers exposed to prenatal inflammation. MIA animal models are often used to study ASD, but also exhibit behaviors consistent with ADHD, including decreased cognitive flexibility (Bitanihirwe et al., 2010), and difficulties in sustained attention and attentional shifting (Vuillermot et al., 2012). There are also animal models for the hyperactivity symptoms of ADHD. Children with ADHD tend to exhibit this symptom in environments they are comfortable in, as opposed to new situations and places, which is seen in animal models as increase locomotor behavior in the home cage, as opposed to a new stressful setting. Offspring of mothers exposed to poly(EC) (an infection) during gestation, show increases in locomotor behavior in their home cage (Missig et al., 2018; Miller et al., 2013).

However, there are also some studies that show the opposite behaviors, and more research needs to be done to find an appropriate animal model of hyperactivity. Of note, the results in these models appears to be dependent on gender, age and context. Male offspring locomotor activity appears to be most affected by MIA, which would be consistent with symptom presentation across genders in humans. MIA animal models also display impulsivity, another key feature of ASD. In rodent models this is exhibited by increased locomotion, decreased inhibition, social intrusiveness and aberrant social behaviors. Lastly, MIA animal models also demonstrate impaired working memory and executive functioning deficits, similar to their human counterparts with ADHD. These behavioral changes correlate with structural changes to the brains of animal models, including

decreased overall brain volume and volume of cortical areas associated with ADHD. Exposure to MIA during gestation also alters the function of neurotransmitters associated with ADHD symptoms, including dopaminergic, serotonergic, glutamatergic and GABAergic systems, which is seen in both animal and human studies.

Although the data is preliminary, individuals with ADHD also present with higher rates of atopic immune disorders and have higher serum cytokine levels than their neurotypical peers (Lin et al., 2016; Instanes et al., 2017; Schans et al., 2017; Schmitt et al., 2010; Miyazaki et al., 2017; Anand et al., 2017; Darwish et al., 2018). Preliminary studies also show an association between proinflammatory serum cytokines and ADHD symptom severity (Oades et al., 2010), with lower levels of cytokines present in those with ADHD currently taking methylphenidate.

The endocannabinoid system, and disruptions to its functioning, may also contribute to ADHD symptomatology (Giuffrida et al., 2001). Endocannabinoids play a key neuromodulatory role in dopamine-related pathophysiological responses, like those involved in ADHD (Tzavara et al., 2006). N-4-hydroxyphenyl-arachidonylamide (AM404) is an inhibitor of endocannabinoid reuptake, increases circulating anandamide levels and inhibits motor activity, and reduces behavioral responses to dopamine agonists. In juvenile spontaneously hypertensive (SHR) rats, an animal model with hyperactivity and attention deficits, the administration of AM404 normalizes these behaviors (Beltramo et al., 2000). This suggests that inhibitors of endocannabinoid inactivation may alleviate dopamine dysfunction symptoms. It also confirms the role of the endocannabinoid system in psychomotor activity, and in ADHD pathophysiology. Genetic studies of polymorphisms related to ADHD symptomatology have also confirmed the role of the endocannabinoid system. A polymorphism in the endocannabinoid degrading enzyme FAAH (FAAH rs2295633) was found to be significantly associated with ADHD in a study of children

with ADHD compared to healthy controls (Ahmadalipour et al., 2020). The FAAH gene is involved in reward and addiction, via its effects on the endocannabinoid and dopaminergic pathways. It has a direct effect on the degradation of endocannabinoids in the brain and is linked to arousability. Increased levels of FAAH are linked to decreased levels of endocannabinoids, and if FAAH is inhibited, the subsequent increase in endocannabinoid level is shown to reduce anxiety levels and increase aversive memory extinction in animal models.

Oxidative stress may also contribute to the pathophysiology of ADHD (Joseph et al., 2015). A meta-analysis of six studies examined the association of ADHD and oxidative stress and antioxidant status in medication naïve patients with ADHD and neurotypical controls. Although the association between ADHD and antioxidant status was not significant, the association between oxidative stress and ADHD could not be accounted for by publication bias, sample characteristics, study design features, or unusual results. Although preliminary, these results suggest that individuals with ADHD have an insufficient response to oxidative stress, resulting in oxidative damage. This is demonstrated by the increased ratio of oxidative to antioxidative status in the ADHD group. Oxidative damage can include, but is not limited to, altered protein structures, epigenetic changes, and mitochondria dysfunction.

C.9. Pharmacological and Psychological Treatments

ADHD is one of the most commonly diagnosed and treated childhood neurodevelopmental/psychiatric disorder, with wide variations in medical practice across the globe. Psychological interventions include behavioral therapies, cognitive training, and neurofeedback. Behavioral interventions have been extensively studied and form a core part of intervention guidelines for ADHD. Behavioral therapies in combination with stimulants are superior to the use of only medication, but stimulants continue to be superior to behavioral therapy,

cognitive therapy, and non-stimulants (Catalá-López et al., 2017). Pharmacological interventions for ADHD include not only stimulants, the most supported and evidence-based treatment, but also non-stimulants, antidepressants, antipsychotics, and other unlicensed drugs. The treatment process can be very complex.

D. The Interrelationship of ASD and ADHD

There is significant overlap and co-morbidity between the symptoms of ASD and ADHD, and there may be overlap in the underlying biology that accounts common features that supersede traditional diagnostic categories. The most recent edition of the DSM allows for a dual diagnosis of ASD and ADHD, recognizing the significant overlap of these disorders and that they frequently co-occur. The diagnostic assessments often used to identify these disorders also overlap. I have included a list of common assessments at **Appendix 3**.

Between 30% and 75% of children with a diagnosis of ASD present with symptoms of ADHD, and 20% to 60% of those with ADHD present with the social difficulties common to ASD (Grzadzinski et al., 2016). The variance in prevalence rates can be explained by the only recent allowance to give dual-diagnoses in the DSM-5.

Children with ADHD regularly present with social dysfunction, and these social communication deficits are similar to those present in ASD. Restricted and repetitive behaviors, common to ASD, are also found in those with ADHD. ASD symptoms appear to be related to the severity of symptom presentation in those with ADHD, with those with more severe behavioral difficulties, oppositional behaviors and depression, being more likely to have symptoms of ASD. (Charman et al., 2007; Clark et al., 1999; Cooper et al., 2014; Frazier et al., 2008; Greene et al., 1996; Grzadzinski et al., 2011; Hus et al., 2007; Hus & Lord, 2013; Luteijn et al., 2000; Martin et al., 2014; Marton et al., 2009; Mulligan et al., 2009; Nijmeijer et al., 2009; Reiersen et al., 2007).

ADHD and ASD are noted to share similar endophenotypes, including difficulties with emotion regulation, externalizing behaviors, and social communication deficits. This could account for the severity of impairment present in those with ASD and ADHD, as children with both diagnoses are noted to have greater cognitive and social impairments and higher rates of externalizing and internalizing behaviors. Children with ASD and ADHD perform worse on continuous performance tasks, including presenting with more attention deficits, higher activity levels and greater impulsivity than children with ASD alone (Stevanovic et al., 2022).

There is considerable genetic, neuropsychological and clinical overlap between ASD and ADHD, and the DSM-5 now allows for the two to be diagnosed concurrently. Studies have shown that between 22% and 83% of children with ASD have symptoms that meet criteria for ADHD (Sokolova et al., 2017). Children with ADHD are also shown to have high rates of ASD symptomatology. A recent study showed that 12.5% of children currently diagnosed with ADHD also had an ASD diagnosis (Zablotsky et al., 2017). ASD and ADHD share about 50% to 72% of contributing genetic factors, and have similar deficits in motor speed, social cognition, impulsivity and executive function (Sokolova et al., 2017). Inattention and decreased attentional switching capacity also overlap and may be linked to similar biological pathways. In clinical practice it may be difficult to determine if the impulsivity of ADHD is responsible for the social communication problems of ASD, or vice versa, and if the repetitive behaviors of ASD are mistaken for hyperactivity of ADHD, or vice versa. Thus the two diagnoses may be difficult to tease apart (Sokolova et al., 2017; Zablotsky et al., 2017).

There is significant between-group overlap and within-group heterogeneity, for complex disorders such as ASD and ADHD, as well as with other neurodevelopmental disorders. Clinicians must take a transdiagnostic approach in their assessments not only in children, but across the

lifespan (Kushki et al., 2019). Without this approach, the similarities in behavioral profiles between these disorders could lead to challenges in both the diagnosis and intervention efforts, particularly as individuals can have comorbid diagnoses of these disorders, with their own unique symptom profiles.

IV. NEURODEVELOPMENT AND APAP

A. Background of Acetaminophen

Acetaminophen, also known as paracetamol, is a widely used ingredient found in many over-the-counter (OTC) and prescription medicines for relieving fever and pain. The most well-known brand name for APAP is Tylenol®, but it is available under various other brand names and formulations. APAP is often combined with other active ingredients to treat conditions like allergies, coughs, colds, flu, and sleeplessness. In prescription medications, it is used alongside other ingredients to manage moderate to severe pain. It comes in different forms such as syrups, tablets, caplets, capsules, effervescent tablets, injections, suppositories, and more.

APAP was first developed by pharmacologist Joseph von Mering in 1893 through reacting p-nitrophenol with tin and glacial acetic acid. (Ayoub, 2021). This newly synthesized compound was known to have analgesic (pain-relieving) and antipyretic (fever-reducing) properties. APAP was approved by the U.S. Food and Drug Administration (FDA) for prescription use under the brand name Tylenol®, and in 1955, it became available for nonprescription OTC use in the United States. Since its approval by the FDA, acetaminophen has become one of the most widely used OTC non-narcotic analgesic agents for treating mild to moderate pain and fever (Ayoub, 2021).

When ingested, APAP is quickly absorbed from the gastrointestinal tract and reaches peak concentrations in the blood within 1 to 2 hours. It is primarily metabolized in the liver and eliminated mainly through the urine. The exact mechanism of action of APAP is not completely understood, but it is believed to involve several processes in the body. The primary mechanism is

thought to be the inhibition of prostaglandin synthesis in the central nervous system (CNS) (Bührer et al., 2021). Prostaglandins are chemical messengers that play a role in inflammation, pain, and fever that are produced in response to injury or illness and contribute to the sensitization of pain receptors and the generation of fever. APAP is believed to inhibit the activity of the enzyme cyclooxygenase (COX), particularly the COX-2 isoform, which is responsible for the synthesis of prostaglandins. By inhibiting COX-2, APAP reduces the production of prostaglandins in the CNS. This, in turn, helps to alleviate pain and reduce fever. Unlike nonsteroidal anti-inflammatory drugs (NSAIDs), such as ibuprofen or aspirin, APAP has limited effect on COX-1, which is involved in maintaining the protective functions of the stomach lining and platelet aggregation. While APAP has analgesic (pain-relieving) and antipyretic (fever-reducing) effects, it has limited antiinflammatory properties relative to NSAIDs. Its action primarily focuses on the CNS and does not significantly impact peripheral tissues (Anderson, 2008; Ghanem, 2016). APAP's analgesic effect may be weaker than previously thought (Moore, et al., 2014). For instance, Moore et al. concluded that ibuprofen produced more effective pain relief in patients than APAP at standard doses in different painful conditions (Moore et al., 2014).

Consumers may unintentionally misuse non-prescription medications like APAP, including taking more than the recommended dose according to the product label (Wolf, et al., 2012). This may be due to the consumer's misconception that APAP is harmless (Wolf, et al., 2012). Additionally, access to higher doses of APAP may increase the risk of unintentional misuse and lead to up-dosing. For instance, Martinez-De La Torre, et al. found that after a 1,000 mg tablet of APAP was introduced, the number of accidental poisoning cases due to APAP increased (Martinez-De La Torre, et al., 2020).

A.1. Questionable Safety Profile For Prenatal Use of Acetaminophen

In my clinical practice, I have experience engaging in a risk/benefit analysis when prescribing and/or recommending medications to pregnant women. In that role, it is important to engage in a meaningful conversation with the pregnant patient discussing the benefits as well as the potential risks of taking a medication while pregnant.

To undertake these risk-benefit calculations and recommendations for my pregnant patients, it is necessary that a drug manufacturer or seller disclose all potential risks and adverse pharmacological effects associated with taking the drug. Full disclosure of potential risks, adverse effects, or risk rating allows me to effectively inform my patients of the risks and benefits associated with the drug and to provide accurate recommendations. This is critical because there is an asymmetry of information between the manufacturer and healthcare providers, and we rely on the manufacturers to provide truthful information. If manufacturers and sellers do not provide comprehensive and adequate information about the potential risks or adverse effects of a particular drug, including a risk rating, healthcare professionals are unable to make definitive, evidence-based clinical decisions and recommendations for their patients' treatment and care.

APAP has been sold and represented as safe for ingestion during pregnancy for decades, and Johnson & Johnson has represented to clinicians, such as myself, that it is a "Category B" pregnancy drug category. From 1979 through 2015, the FDA required prescription drugs to be classified into one of five categories to indicate risk of use while pregnant, and such classification was required to be included on the product label (Pernia & DeMaagd, 2016).

FDA Pregnancy Drug Categories		
Category A	No risk shown in human studies. Adequate and well-controlled studies have failed to demonstrate a risk to the fetus in the first trimester of pregnancy (and there is no evidence of risk in later trimesters).	
Category B	No risk in animal studies (there are no adequate studies in humans, but animal studies did not demonstrate a risk to the fetus). Animal reproduction studies have failed to demonstrate a risk to the fetus and there are no adequate and well-controlled studies in pregnant women.	
Category C	Risk cannot be ruled out. Animal reproduction studies have shown an adverse effect on the fetus and there are no adequate and well-controlled studies in humans, but potential benefits may warrant use of the drug in pregnant women despite potential risks.	
Category D	Evidence of risk (studies in pregnant women have demonstrated a risk to the fetus; potential benefits of the drug may outweigh the risks). There is positive evidence of human fetal risk based on adverse reaction data from investigational or marketing experience or studies in humans, but potential benefits may warrant use of the drug in pregnant women despite potential risks.	
Category X	Contraindicated (studies in pregnant women have demonstrated a risk to the fetus, and/or human or animal studies have shown fetal abnormalities; risks of the drug outweigh the potential benefits). Studies in animals or humans have demonstrated fetal abnormalities and/or there is positive evidence of human fetal risk based on adverse reaction data from investigational or marketing experience, and the risks involved in use of the drug in pregnant women clearly outweigh potential benefits.	

Table 1. Content and Format of Labeling for Human Prescription Drug and Biological Products; Requirements for Pregnancy and Lactation Labeling (Federal Register/Vol. 73, No. 104/Thursday, May 29, 2008).

Based on some internal Johnson & Johnson documents, it seems there is some question as to whether Tylenol should be classified as "Category B" or whether it ever was (Exhibit 25 to Deposition of Exhibit 27 to Deposition of Dep

In addition, I have identified two other products containing APAP that acknowledge fetotoxicity studies concerning oral administration of acetaminophen in pregnant rats, studies which would render APAP a "Category C" under the FDA's category system. Ofirmev is a pure APAP injection, and that label states that animal studies in pregnant rats that received oral APAP "showed evidence of fetotoxicity" and that it should only be given to a pregnant woman only if "clearly needed" (Exhibit 9 to Deposition of "the Maternal Health team for the FDA ultimately designated Ofirmev as a Category C drug, meaning risk cannot be ruled out as animal reproductions studies have shown an adverse effect on the fetus and there are no adequate well controlled studies on humans. (Dept of Health Ofirmev Review, 2010).

Second, Ultracet is a pharmaceutical product manufactured by Janssen, a subsidiary of Johnson & Johnson, that contains APAP and tramadol. It is a combination of acetaminophen and tramadol. The Ultracet label has a section that solely focuses on APAP that says, "acetaminophen approximately 1.3 times the maximum human daily dose (MRHD) showed evidence of fetotoxicity and increases in bone variations in the fetuses" (Ultracet Label).

A.2. Brain Development in Utero

The development of the CNS and brain in utero is a complex, highly orchestrated process that involves the proliferation and migration of cells, the formation of neural circuits, and the establishment of synaptic connections. There are multiple stages to human brain development, including neuralation, neurogenesis/proliferation, cell migration, differentiation, synaptogenesis, and myelination.

The nervous system originates from the ectodermal layer of the germ disc (the outermost layer of the embryo), which is the flat surface adjacent to the amnion (the innermost membrane that encloses the embryo) (Rodier, 1995). Along the midline of the disc, a groove emerges, and the folds on each side come into contact and merge. This fusion gives rise to a tube structure that remains open at the head and tail ends of the developing embryo, then the neural tube closes at the head and tail ends first, and then in the middle. Once the neural tube is closed, it forms the brain and spinal cord. This process is called neurulation. The process of tube formation initiates in the cervical region and progressively extends towards the head and tail of the embryo. Typically, the closure of the tube is observed between approximately three to four weeks after conception.

The neurogenesis/proliferation stage begins during the first month of gestation in humans and involves the production of neurons (nerve cells), which begins even before the neural tube is closed (Rodier, 1995; Rice & Barone, 2000). The CNS is made of dozens of different types of neurons (Rodier, 1995). Neural stem cells divide and differentiate into precursor cells, which then develop into neurons. Neurogenesis primarily occurs in specific regions of the brain, such as the ventricular zone. During this stage, the overproduction of neurons is balanced out by a process of programmed cell death called apoptosis.

After neurogenesis, newly formed neurons migrate from their site of origin to their final destinations in the brain (Rodier, 1995). This process is critical for establishing the correct architecture and connectivity of the developing brain. Neurons migrate along specialized pathways, guided by chemical signals and radial glial cells. The majority of cell migration takes place during the early stages of gestation when the distances within the brain are relatively short. However, the extensive migrations of small cells in regions like the cerebral cortex, hippocampus, and cerebellum persist for several months following birth.

Once neurons reach their proper locations through migration, it typically follows one of two paths: differentiation into a fully developed neuron with axons and dendrites, or elimination through apoptosis (Rodier, 1995). Axon development relies on growth cones, small structures at the axon's edge, which guide growth towards specific targets while avoiding others. Early dendrites emerge as thick strands with few spines (small protrusions) extending from the cell body. As dendrites mature, the number and density of spines increase, enhancing the likelihood of dendrites establishing connections with neighboring axons. These connections between dendrites and axons form the basis for synaptic connections between neurons, which are essential for proper brain function.

To fulfill their role as signal transmitters, neurons must establish connections, which necessitates the development of specialized structures on the surfaces of both sending and receiving neurons (Rodier, 1995). The site of contact where these structures meet is known as a synapse. It is at the synapse that neurons interact and facilitate the transmission of signals to achieve mature functionality. During synaptogenesis, synapses begin to form. Axon terminals establish contact with dendrites or other target cells, thereby creating functional connections. Synaptic formation and refinement occur in a highly dynamic and activity-dependent manner.

Myelination involves the production of a fatty substance called myelin, which wraps around axons. Myelin acts as an insulating sheath, enhancing the speed and efficiency of nerve signal transmission (Rodier, 1995). Myelination progresses gradually throughout childhood and continues into adolescence.

Neural development extends from gestation through adolescence (Rice & Barone, 2000). Critically, the formation of the blood-brain barrier is a gradual process that commences during fetal development but does not reach completion approximately six months after birth in humans.

A.3. Susceptibility of the Developing Brain to Toxicity

The developing brain is highly sensitive to environmental influences. As noted above, the blood-brain barrier, which protects the brain, is not fully formed during fetal development. As a result, the developing brain is more permeable to chemicals and medications compared to the mature brain (Rodier, 1995). Additionally, the brain undergoes rapid growth during the second trimester of pregnancy, followed by a series of critical processes (including neurulation, neurogenesis/proliferation, migration, differentiation, and synaptic pruning) throughout early childhood (Rodier, 1995).

This prolonged development makes the brain more vulnerable to exposures and insults than other organs in the body (Rodier, 1995; Rice & Barone, 2000). Additionally, the brain is composed of various types of neurons and other cells like oligodendrocytes, astrocytes, and microglia, each with its own distinct growth phase and potential susceptibility to toxicity. The vulnerability of the developing brain to the effects of chemicals during pregnancy is widely recognized as a biological fact in the scientific community. Factors such as the incomplete development of the blood-brain barrier and the ongoing growth, differentiation, and pruning of neurons contribute to the heightened vulnerability of the developing brain to exposures.

Due to the intricate nature of the brain, which consists of numerous interconnected circuits, the establishment of fully mature neural systems involves a greater number of developmental processes compared to other tissues. Consequently, there are increased opportunities for potential harm or injury. The most significant aspect of the CNS in relation to developmental mishaps, however, is the prolonged duration over which CNS development takes place.

B. Interrelationship Between Genetics and/or Fever/Infection and APAP

The Maternal Immune Activation (MIA) hypothesis discusses the relationship between infection or fever during pregnancy and an increased risk for ASD, ADHD, and other neurodevelopmental disorders in offspring. Viral infection during the first trimester resulting in hospitalization, and bacterial infection in the second trimester are associated with a diagnosis of ASD in offspring (Atladóttir et al., 2010). Additionally, self-reported influenza during pregnancy was associated with a twofold increased risk of infantile autism; while febrile episodes lasting more than 7 days are associated with a threefold increase in risk (Atladóttir et al., 2012). It is noted that these maternal infections and febrile episodes may increase the mother's exposure to APAP and other NSAIDs, and that the two hits of infection/fever during pregnancy and fetal exposure to APAP could further exacerbate fetal insult, increasing the risk for the development of neurodevelopmental disorders, including ASD and ADHD. The majority of studies reviewed examining the association between prenatal APAP exposure and development of ASD/ADHD symptoms do control for maternal infection and fever, and the association is still present.

The effect of MIA on offspring neurodevelopment and behavior has been demonstrated in multiple animal models using a variety of immune system activators, including the influenza virus, the viral mimetic polyinosinic-polycytidylic acid (polyI:C), interleukin-6, and the bacterial endotoxin lipopolysaccharide (LPS). Early prenatal stress can also act as an immune system activator, and it has been shown to produce changes in gene expression patterns, including the up-

regulation of immune-related genes of proinflammatory cytokines and chemokines (Bronson & Bale, 2014). Notably, the timing of the MIA is critical to the subsequent effect on the fetus, as early first trimester and second trimester insults causing the most significant insult (Garay et al., 2013). Alterations in brain cytokine levels are found throughout the lifespan of MIA offspring. In both the frontal cortex and cingulate cortex, proinflammatory and anti-inflammatory cytokines are elevated in the early postnatal period, lower than controls during early adolescence, and elevated again in the adult brain. The hippocampus also has alterations of cytokine levels at each age level. but these are distinct compared to other brain areas. There also appears to be a widespread decrease in cytokine levels during critical periods of synaptogenesis and plasticity in MIA offspring compared to controls. This is in contrast to the expected pro-inflammatory phenotype and may indicate an alternative pathway for cytokines to impact brain connectivity and subsequent behavior in ASD. Of note, brain cytokine levels are different than serum cytokine levels, indicating that the levels in brain tissue are not contaminated by serum. Additionally, ASD offspring have no changes in blood-brain barrier permeability, immune cell infiltration or microglial density (Garay et al., 2013; Patterson, 2012; Ito et al., 2010; Shi et al., 2009; Arrode-Brusés & Brusés, 2012).

Offspring of MIA mice exhibit the three core features of ASD, including deficits in communication, sociability, and the presence of repetitive and stereotyped behavior. Mirroring the results observed in animal models, large epidemiological studies have found significant associations between maternal viral infections during the first trimester of pregnancy and increased autism risk in their children (Atladóttir et al., 2012). Maternal infections from a variety of microorganisms, including influenza, varicella, and rubella, have been associated with an increased risk for developing ASD, demonstrating that it is not the particular pathogen that is responsible, but rather the generalized activation of the maternal immune system during pregnancy

(Atladóttir et al., 2012; Zerbo et al., 2014). Additionally, prolonged febrile episodes and antibiotic use has been linked to an increased risk for infantile ASD (Atladóttir et al., 2012). A study completed by the Childhood Autism Risks from Genetics and Environment (CHARGE) group evaluated both maternal influenza and maternal febrile episodes during pregnancy and its relationship with ASD risk. The development of ASD or developmental delays was significantly associated with maternal febrile episodes but not with maternal influenza during pregnancy. Additionally, the ASD risk due to fever was attenuated when mothers reported taking antipyretic medications (Zerbo et al., 2013). These insults are comparable to a study completed in Denmark that showed an association between admission to the hospital in the first trimester for maternal viral infection and the second trimester for maternal bacterial infection with a diagnosis of ASD in offspring (Atladóttir et al., 2010). However, not all infections have the same result, as some viral infections (i.e., influenza) appear to be heavily correlated with increased ASD risk, while urinary tract infections, upper respiratory infections, and cystitis do not appear to be risk factors. Although there is significant data from mouse models on the detriment of MIA, further work is needed in humans to expand on the epidemiological research mentioned above.

C. Role of Animal Studies

Animal models provide critical information to epidemiological, clinical, and biomedical research by offering a controlled experimental setting to study diseases/disorders and their mechanisms. Animal models mimic aspects of biologic processes or diseases found in humans and have an important role in studying toxicity, neurodevelopment, pharmacokinetics, and in completing the pre-clinical testing often needed for drug development. By mimicking human conditions and exposures in animals, researchers can study the progression, etiology, and pathophysiology of diseases/disorders. This understanding is crucial for identifying risk factors, developing prevention strategies, and designing targeted interventions.

Animal models are extensively employed in investigating the neurobiology of psychiatric disorders and understanding how current and new psychotropic medications work (Nestler et al., 2002; Desbonnet et al., 2012). Using animal models, neuroscience has gained valuable insights, although it should be acknowledged that these models are limited to simulating specific aspects of psychiatric syndromes rather than providing an entirely accurate and comprehensive representation of the conditions (Neumann et al., 2011; Stephens et al., 2013).

Animal models also provide researchers with a controlled experimental environment where various factors can be manipulated and studied. This control allows for the isolation of specific variables, which helps establish causal relationships between exposures and health outcomes. Animal models also enable the systematic testing of hypotheses and the evaluation of potential interventions in a controlled setting.

Animal models offer certain practical advantages in terms of feasibility and logistics by allowing for longitudinal studies, precise follow-up, and standardized data collection. More generally, animal models can be used to study rare diseases, complex interactions, and long-term effects that may be difficult to assess in human populations due to sample size limitations or ethical constraints. In the case of studying the association between maternal APAP use during pregnancy and the association with neurodevelopmental disorders like ASD and ADHD, for instance, it is unethical to perform randomized controlled trials (RCTs) in humans. However, multiple meaningful animal studies have been performed to study the association between environmental exposures during pregnancy and the development of neurodevelopmental disorders in offspring. These animal studies allow us to analyze the relationship between fetal exposures and the development of symptom domains associated with both ASD and ADHD, including hyperactivity, social deficits, repetitive behaviors, and irritability. For example, the valproate mouse model is an

animal model of autism that reliably demonstrates social deficits, repetitive behaviors, and other symptom domains of the autism spectrum (Rodier, 1996; Nicolini & Fahnestock, 2019). Drugs developed for the treatment of autism are often screened in this and other animal models to determine whether they should be pursued in clinical trials in humans. For these reasons, animal studies have been used for decades to investigate causation in ASD and ADHD (Rodier, 1996).

As further explained in the expert report of Dr. Pearson, animal models serve as a bridge between basic research and clinical applications. Findings from animal studies can inform and guide human epidemiological studies, clinical trials, and the development of preventive or therapeutic strategies. Animal models provide insights into potential mechanisms, biomarkers, and treatment targets, aiding in the translation of research findings into practical applications for human health. Further, animal models are instrumental in the validation and preclinical testing of potential therapies, vaccines, or interventions before they are tested in humans. Animal studies help assess safety, efficacy, dosage, and potential adverse effects, providing critical information for the development and refinement of medical interventions. In this case, animal studies allow researchers to look at the presentation of neurodevelopmental symptoms over the lifespan and its relationship to various fetal exposures independent of other confounders.

D. Mechanism of Action & Biological Plausibility

As more thoroughly detailed above, fetal brain development is a complex, tightly regulated process that, if disrupted, can lead to long-lasting effects on the brain. As explained below, APAP can impact fetal brain development and lead to neurodevelopmental disorders in offspring through multiple mechanisms of action.

The causal association between fetal APAP exposure and neurodevelopmental disorders, specifically ASD and ADHD, is biologically plausible based on the known mechanisms of action

discussed below and as discussed in greater detail within the expert reports of Drs. Cabrera and Pearson.

D.1. APAP Can Directly Affect the Fetus

APAP crosses the placenta barrier and has endocrine-disrupting properties that interrupt fetal brain development by interfering with maternal hormones or via neurotoxicity, including the induction of oxidative stress that could result in neuronal death. The placenta, the organ developed during pregnancy, acts as a link between the mother and developing fetus and serves as a barrier between the maternal and fetal circulatory systems (Gude et al., 2004). This separation of circulatory systems protects the fetus from potentially harmful substances within the mother's circulation system, such as drugs, infectious agents, and toxins (Robbins et al., 2012). In some instances, however, a substance may cross the placental barrier and enter the fetal circulatory system. APAP is a small molecule that is known to cross the placenta and enter the fetal circulatory system (Weigand et al., 1984; Thiele et al., 2013; Nitsche et al., 2017). Thus, APAP can reach the fetus and affect its development (Thiele et al., 2013).

D.2. Excess NAPQI Formation

APAP has multiple important metabolic pathways, including glucuronidation and sulfation. APAP is primarily metabolized in the liver through conjugation with glucuronic acid (reduced glutathione or "GSH") and sulfate, which results in the excretion of nontoxic final products (Bauer et al., 2018). These metabolic routes generally yield inactive, non-toxic, final products. Glucuronidation is the primary metabolic pathway in adults, while sulfation is the primary pathway for APAP metabolism until ages 10–12 years. One of the secondary pathways is mediated by cytochrome P-450. However, the remainder is oxidized in the liver through several CYP450 isoforms (CYP2E1, CYP1A2, CYP3A4, and CYP2A6) to produce the metabolite N-acetyl-

benzoquinone imine (NAPQI). NAPQI is generally normalized by combining with GSH, which is converted to non-toxic metabolites and excreted (Toussaint et al., 2010).

If concentrations of NAPOI exceed the available GSH, NAPOI initiates a mitochondrial cascade that leads to accumulation of reactive oxygen species and cell death (Jaeschke, 2021; Jaeschke, 2020). Supratherapeutic doses of APAP may lead to excessive NAPOI formation and result in acute liver failure (ALF) and hepatic encephalopathy (Jetten et al., 2016; Zhao & Pickering, 2011: Butterworth, 2011). Even therapeutic doses have been found to be associated with hepatotoxicity. When cellular GSH is depleted, NAPOI binds to cellular proteins including mitochondrial proteins. This can reduce the body's ability to detoxify, which can lead to immune system activation and oxidative stress. It has been shown that brain cells can metabolize APAP to produce NAPQI (Ghanem et al., 2016; Upadhya 2000). Ghanem's finding that NAPQI is generated in the brain reveals that cortical inflammation and oxidative stress may contribute to abnormal neurodevelopment. Male mice treated with APAP have shown greater GSH depletion, and altered GSH homeostasis has been observed in children with ASD and their mothers (Oken et al., 2007; Williams et al., 2007; Bowers et al., 2011). Women who used APAP in the third trimester had an increased risk of preeclampsia in the Danish Birth Cohort (Rebordosa et al., 2010). Additionally, preeclampsia has been linked to decreased glutathione levels, which could be further exacerbated by APAP use, and has been linked to an increased risk of having a child with ASD (Mann et al., 2010; Buchmayer et al., 2009). The cytochrome P-450 pathway could also play a role in the reduced sulfation capacity observed in pregnancy, which can activate immune response pathways, including pro-inflammatory cytokine interleukin signaling (Davies et al., 1994; Lee et al., 2009). Similar cytokines are involved in the maternal immune activation hypotheses of ASD pathophysiology. Additionally, therapeutic doses of APAP are also linked to immune activation and pro-inflammatory cytokine signaling (Jetten et al., 2012; Wright et al., 2007; Deverman & Patterson, 2009). Thus, prenatal exposure to APAP may trigger maternal immune activation pathways, similar to those noted in the MIA pathophysiology of ASD. The mechanism of analgesic action in APAP metabolism involves the deacetylation of APAP in the liver, which subsequently produces p-aminophenol. P-aminophenol is involved in APAP nephrotoxicity and in mouse models produces significant losses of cortical neuron viability (Schultz et al., 2012).

D.3. Oxidative Stress

Oxidative stress is a phenomenon that occurs due to an imbalance between the production of reactive oxygen species (ROS) and the body's ability to reduce their harmful effects by using antioxidants (Manivasagam et al., 2020). The human brain uses the most oxygen of any organ in the body (Liu et al., 2022). The developing human brain is highly susceptible to harm caused by reactive oxygen and reactive nitrogen species, in part due to abundance of unsaturated fatty acids, elevated oxygen consumption, limited presence of antioxidants, significant metal content that facilitates free radical production, and considerable population of delicate immature cells (Liu et al., 2022; Ikonomidou & Kaindl, 2011). The developing fetal brain can be adversely affected by oxidative stress, and prenatal APAP exposure has been shown to increase oxidative stress through multiple mechanisms (Parker et al., 2017). APAP depletes glutathione and other antioxidants that neutralize ROS (Brune et al., 2015). Glutathione is used when APAP is metabolized in the liver, and its resulting depletion means that glutathione is not available for other tissues such as the fetal brain (Brune et al., 2015). The fetal brain is rapidly growing and maturing and requires high energy metabolism, but at the same time, it is very vulnerable to oxidative stress. Oxidative stress can result in cellular damage, disrupted neural connection formation, and abnormal brain function (Ikonomidou et al., 2010). APAP exposure in utero has been shown to increase oxidative stress

markers in the fetal brain and has been associated with adverse neurodevelopmental outcomes or deficits in animal studies (Bauer et al., 2018; Blecharz-Klin et al., 2015, 2016, 2017; Viberg et al., 2014).

D.4. Effects on the Prostaglandin System

APAP's antipyretic, or fever reducing, effect is suggested to be due to its effect on the prostaglandins, which mediate the generation of fever and are involved in neuronal development and synaptic plasticity in the developing brain (Bauer et al., 2018; Mirrasekhian et al., 2018; Dean et al., 2012). APAP's antipyretic properties are attributed to its ability to inhibit cyclooxygenase enzymes in the brain from producing prostaglandins (Mirrasekhian et al., 2018). It has been postulated that disruption in the signaling of prostaglandin E2 pathway (due to genetic defects or exposure to environmental factors) during critical periods of brain development can lead to neurodevelopmental disorders such as ASD (Tamiji & Crawford, 2011). Mouse models have shown that abnormal prostaglandin ED signaling and cyclooxygenase 2 is related to ASD behavior and pathology (Wong et al., 2019; Rai-Bhogal et al., 2018). In the pre- and post-natal periods, alterations in lipid signaling pathways can negatively impact neurodevelopment and lead to autism. Studies collectively suggest that lipid signaling may play an important role in the pre- and postnatal periods, and alterations of this pathway can negatively impact the development of the nervous system and lead to ASD (Tamiji & Crawford, 2011).

D.5. Endocannabinoid Dysfunction

A proposed mechanism of APAP's analgesic action is modulation of the endocannabinoid system (Bauer et al., 2018). APAP can adversely affect fetal brain development by altering the cannabinoid system. (Angelis et al., 2021). APAP is thought to produce analgesic effects through the activation of CB₁ receptors, and in blocking these receptors, the analgesic effect of APAP is

removed. In the CNS, APAP metabolism produces para-aminophenol, which combines with arachidonic acid to produce *N*-arachidonoylphenolamine (AM404). This reaction is catalyzed by fatty acid amide hydrolase (FAAH), a central enzyme of the endocannabinoid system that catabolizes anandamide and 2-arachidonoylglycerol (both endocannabinoids). AM404 blocks the reuptake of anandamide, acting as an indirect agonist against the CB₁ receptors. Repeated exposure to APAP sets the level of anandamide lower, and lower levels are observed as decreased endocannabinoid tone in ASD and related disorders (Schultz et al., 2021). Thus, APAP may interfere with the endocannabinoid system during in utero development inducing long-lasting functional alterations in the developing brain.

The CB₁ receptors play an important role in neuron differentiation, axonal migration, and the establishment of neuronal connectivity (Bauer et al., 2018; Wilson & Nicoll, 2002; Doenni et al., 2016; Basavarajappa et al., 2009). Abnormal brain connectivity in children with ASD may be due to lack of CB1 axon guidance (Schultz & Gould, 2016; Schultz, 2010; McFadden and Minshew, 2013). The CB₂ receptors are important in immune system regulation and occur in immune and microglial cells, but are not affected significantly by APAP (Bauer, et al., 2018; Di Marzo, et al., 2004). APAP is metabolized in the liver to a number of different compounds. One of these compounds, AM404, is an agonist of cannabinoid receptors and may be responsible for the analgesic effects of APAP. AM404 and p-aminophenol, another APAP metabolite, have been shown to be toxic to mouse embryonic cortical neurons (Schultz et al., 2012). In another animal study, acute intraperitoneal administration of APAP showed changes in social behaviors in mice and corresponding elevations in cortical levels of endocannabinoids (Gould et al., 2012).

Of note, the endocannabinoid system is involved in the pathophysiology of ASD (Brigida et al., 2017; Schultz et al., 2021) and may also be involved in the development of ADHD and

related disorders of impulsivity due to its involvement in behavioral inhibition and reward-seeking behaviors (Lafenêtre et al., 2009; Navarrete et al., 2020; Schultz et al., 2019, 2021; Brunkhorst-Kannan et al., 2021; Klinger-Gratz et al., 2018). Thus, APAP may interfere with the endocannabinoid system during in utero development inducing long-lasting functional alterations in the developing brain.

Animal studies provide support for the biological plausibility of endocannabinoid disruption as a mechanism of action. In the BTBR autism mouse model, APAP acts like a cannabinoid and works to improve sociability by increasing the level of anandamide in the frontal cortex (Gould et al., 2012). Thus, damage caused by APAP in utero can be repaired by its use postnatally. This mechanism of a drug causing damage prenatally and then being useful as a treatment postnatally is not uncommon.

This is analogous to the valproic acid (VPA; Depakote) model of ASD. In this VPA animal model of ASD, rats treated with VPA have decreased sociability, which is linked to lower levels of anandamide in the brain (Nicolini & Fahnestock, 2018). Behavioral damage was observed in male rats compared to female rats, consistent with the male:female ratio observed in ASD. Treatments that inhibit the destruction of endocannabinoid anandamide can rescue these social deficits. Prenatal usage of valproate by mothers increases their risk of having children with ASD (Christensen et al., 2013, 2019), and conversely valproate rescues behavioral deficits in children with ASD (Hollander et al., 2001, 2005, 2010). APAP use in animal models causes toxicity and inhibition of fetal testosterone development that significantly disrupts fetal brain development. It also results in the inhibition of cyclooxygenase 2, which can affect long-term potentiation, spatial learning and cerebellar development.

D.6. Endocrine Disruption

The endocrine system consists of a network of hormone-producing glands and organs. The hormones produced in the endocrine system regulate multiple physiological processes, including growth, metabolism, and reproduction. Many of the hormones secreted, including thyroid hormone and growth hormone, cortisol, prolactin, and gonadotropins, are important for fetal brain development. However, endocrine-disrupting pharmaceuticals may interrupt hormone signaling that regulates fetal brain development (Frye et al., 2012). Notably, endocrine disrupters pose the greatest risk during prenatal development, and some may alter neural transmission and formation of neuronal networks (Kajta & Wojtowicz, 2013). Although the current evidence is still being developed, study of other environmental insults that cause fetal endocrine disruption resulting in ASD or ADHD symptoms is being completed, and researchers note that every effort should be made to reduce exposure to endocrine disrupting compounds (Long et al., 2019; Mari-Brauset et al., 2018).

D.7. Altered Brain-Derived Neurotropic Factor

Brain-derived neurotrophic factor ("BDNF") is a protein that is widely expressed in the brain and is involved in several important neurodevelopmental processes and plays a role in the growth, survival, and maintenance of neurons and the nervous system (Barde, 1982). BDNF is released by neurons in response to activity and other stimuli (Huang, 2023). BDNF is implicated in synaptic plasticity, learning, memory, and attention (Garcia et al., 2012). Viberg et al. demonstrated that acute neonatal exposure to APAP during neonatal brain development in mice was shown to affect BDNF levels in the neonatal brain and indicate long-lasting impairment in cognitive function and analgesic and anxiolytic response in adult male mice (Viberg et al., 2014). These behavioral alterations in adulthood may be due to APAP-induced changes to BDNF levels

in the brain during a critical time in development. Studies have shown that dysregulation of BDNF is involved in ASD and ADHD (Bryn et al., 2015; Liu et al., 2015; Meng et al., 2017). BDNF alterations caused by APAP in utero may ultimately be responsible for behavioral and cognitive alterations during childhood that persist into adulthood.

D.8. Epigenetic Effects

Epigenetics is the study of heritable changes in gene expression (that is, turning genes "on" or "off") that are caused by mechanisms other than changes in the underlying DNA sequence (Bernstein et al., 2007). These changes can be caused by environmental factors, such as diet, stress, and exposure to toxins, and they can be passed from parent to offspring. DNA methylation is a type of epigenetic change that works by adding a chemical group to DNA, where it blocks certain proteins that attach to the DNA to "read" the gene, which effectively turns the gene "off." The chemical group can be removed from the DNA through demethylation. During brain development, epigenetic alterations like DNA methylation are important in regulating gene expression (Jeong et al., 2021; Spiers et al., 2015). Brain development involves dynamic orchestration of gene expression, and neurogenesis, neuronal differentiation, and synaptic plasticity are all epigenetically regulated (Spiers et al., 2015).

Defects in certain epigenetic marks can result in neurodevelopmental disorders and affect brain development (Jakovcevski, 2012). Modifications to the epigenome can result in abnormal gene expression, which may lead to neurodevelopmental disorders like ASD and ADHD (Reichard & Zimmer-Bensch, 2021). Carter and Blizard examined whether certain autism genes are targeted by environmental factors and analyzed gene/environment interactions in 206 autism-susceptible genes from the Autworks database to interrogate over one million gene/chemical interactions in the comparative toxicogenomics database (Carter & Blizard, 2016). APAP was identified as a drug

implicated in autism and showed a significant degree of bias towards ASGs. Overall, APAP modified gene expression in 92 ASGs and was a drug with one of the most significant enrichment scores, second-highest after Depakote (valproate), which has a "black box warning" for the fetal risk of neural tube defects (Carter & Blizard, 2016).

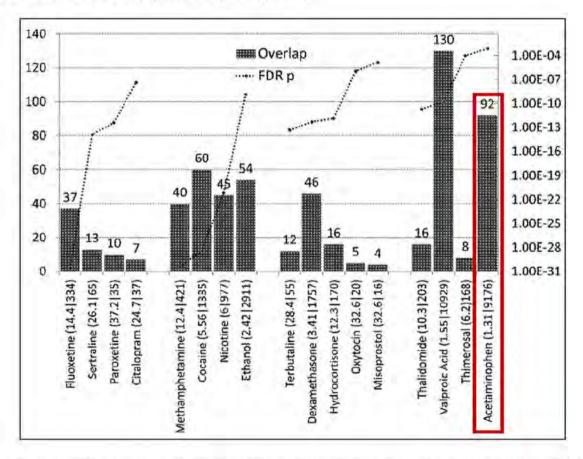


Fig. 2. The number of ASGs affected by drugs implicated in autism (left axis), and p values (right axis). The enrichment ratio and the total number of genes affected by each compound are shown

² Black box warnings (BBWs) are the most potent safety advisories regarding medications that are included in a drug's labeling information as mandated by the Food and Drug Administration (FDA) (Panagiotou et al., 2016). These warnings draw attention to significant risks associated with the use of the drug. The FDA determines whether a black box warning is necessary based on evidence from animal studies, clinical trials, and post-marketing surveillance. From 2005 to 2008, approximately 14% of safety labeling changes involved the addition or modification of black box warnings. Within 25 years of approval, around 20% of approved drugs either receive a black box warning or are withdrawn from the market due to serious adverse effects. Currently, there are over 400 drugs that carry black box warnings, indicating an almost twofold increase in the past 15 years.

after each compound name. First batch = SSRI antidepressants, second = drugs of abuse, third = drugs used during labor, fourth = others (Carter & Blizard, 2016).

Use of APAP during pregnancy has been associated with epigenomic alterations, specifically DNA methylation changes in the placenta, newborn blood, and fetal tissues (Eslamimehr et al., 2022; Addo et al., 2019). In an epigenome-wide association study, Gervin et al. examined whether long-term prenatal exposure to APAP was associated with DNA methylation changes, an epigenomic alteration, changes in cord blood, and clinical ADHD diagnoses in samples selected from the Norwegian Mother and Child Cohort (MoBa) (Gervin et al., 2017). The study found increased differential DNA methylation in genes involved in oxidative stress and neurotransmission (but not ADHD specifically) in children diagnosed with ADHD. Gervin et al. concluded that the study results were compatible with epidemiological evidence showing an increased risk of developing ADHD with long-term fetal exposure to APAP. This is consistent with the finding that APAP modified gene expression in 92 ASGs.

Spildrejorde et al. investigated APAP's effects on a model of early human brain development using a multi-omics approach, which combined datasets from multiple disciplines to gain a more comprehensive understanding of the developing brain (Spildrejorde et al., 2022). Human embryonic stem cells undergoing in vitro neuronal differentiation were exposed to daily media changes with APAP amounts comparable to maternal therapeutic doses. This resulted in APAP-induced chromatin-opening changes linked to gene expression. These methylated and/or expressed genes were related to signaling, neurotransmission, and cell fate-determination. Spildrejorde et al. concluded that, based on the data, APAP may play a causal role in impaired neurodevelopment. Like the other studies reviewed here, epigenome alterations occurring during fetal development can affect neurodevelopment and lead to neurodevelopmental diseases. As these studies show, fetal exposure to APAP can lead to epigenetic changes in a large number of autism-

susceptible genes (earning it the second highest enrichment score), which constitutes a mechanism of action for neurodevelopmental disorders like ADHD and ASD.

V. OPINIONS

Based on my expertise, experience, medical training, and review of the discussed scientific materials, I state the following opinions:

- As recognized by the transdiagnostic approaches to neurodevelopmental disorders, there is
 a strong interrelationship between the neurodevelopmental disorders of ASD and ADHD
 and across neurodevelopmental disorders.
- 2. Based on this interconnectedness of neurodevelopmental disorders, including ADHD and ASD, it is appropriate to review the body of evidence that measures neurodevelopmental disorders and to not limit the analysis to studies that focus on ASD and ADHD as specified outcomes.
- 3. I reviewed the underlying epidemiological literature regarding whether prenatal use of APAP can cause the neurodevelopmental disorders of ASD and ADHD, and that body of literature is consistent with my opinion that to fully investigate and address the question of whether prenatal use of APAP can cause the neurodevelopmental disorders of ASD and ADHD, scientists should look to the full body of neurodevelopmental studies.
- 4. There are multiple, plausible mechanisms of action to explain how APAP can impact fetal brain development and lead to neurodevelopmental disorders in offspring.
- 5. Depending on the timing and duration of APAP exposure to the developing brain, if the suspect mechanisms of injury occur, then one would expect a wide variety of diffuse neurologic symptoms/injuries when the brain develops.
- 6. Based on my review of the literature, the expert reports, and my decades of clinical experience, I would not advise my pregnant patients to take APAP unless they have fever

and to use at the lowest effective dose for the shortest time possible and the lowest possible frequency.

VI. CONCLUSION

In conclusion, as a psychiatrist with a focus in neuropsychopharmacology, it is my opinion that it is appropriate to review the comprehensive evidence that assesses the causal association between exposure to toxic substances and neurodevelopmental disorders when assessing a casual association between an exposure and the specific neurodevelopmental disorders of ASD and ADHD. That is true to assess the causal association between prenatal exposure to APAP and the neurodevelopmental disorders of ASD and ADHD. In addition, I find there are number of plausible biological mechanisms to explain the causal association between prenatal exposure to APAP and the neurodevelopmental disorders of ASD and ADHD. Finally, based on my review of the literature, and the expert reports, as well as decades of clinical experience, I would not advise my pregnant patients to take APAP unless they have fever and to use at the lowest effective dose for the shortest time possible and the lowest possible frequency. I hold these opinions to a reasonable degree of medical and scientific certainty.

Appendix 1

DSM-5, DSM-IV, and ICD for ASD

DSM-5 Criteria for ASD:

- (A) Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history:
 - i. Deficits in social-emotional reciprocity, ranging for example from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
 - ii. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
 - iii. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.
- (B) Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history:
 - i. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
 - ii. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behaviors (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).
 - iii. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).
 - iv. Hyper- or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).
- (C) Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies later in life).
- (D) Symptoms cause clinically significant impairment in social, occupational or other important areas of current functioning.
- (E) These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay.

The DSM-5 diagnostic criteria also allow for the following specifiers: comorbid intellectual impairment, language impairment; known medical or genetic condition or environmental factors; associated with another neurodevelopmental, mental, or behavioral disorder; or with catatonia.

DSM-IV-TR Criteria for ASD:

1. Autistic Disorder:

- a. A total of six (or more) items from (1), (2) and (3), with at least two from (1) and one each from (2) and (3):
 - i. Qualitative impairment in social interaction, as manifested by at least two of the following:
 - 1. Marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction
 - 2. Failure to develop peer relationships appropriate to developmental level
 - 3. A lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)
 - 4. Lack of social or emotional reciprocity
 - ii. Qualitative impairments in communication as manifested by at least one of the following:
 - 1. Delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime)
 - 2. In individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others
 - 3. Stereotyped and repetitive use of language or idiosyncratic language
 - 4. Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level
 - iii. Restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:
 - 1. Encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus
 - 2. Apparently inflexible adherence to specific, nonfunctional routines or rituals
 - 3. Stereotyped and repetitive motor manners (e.g., hand or finger flapping or twisting, or complex whole-body movements)
 - 4. Persistent preoccupation with parts of objects
- b. Delays or abnormal functioning in at least one of the following areas, with onset prior to age 3 years: (1) social interaction, (2) language as used in social communication, or (3) symbolic or imaginative play
- c. The disturbance is not better accounted for by Rett Disorder or Childhood Disintegrative Disorder

2. Asperger's Disorder:

a. Qualitative impairment in social interaction, as manifested by at least two of the following:

- i. Marked impairment in the use of multiple nonverbal behaviors such as eyeto-eye gaze, facial expression, body postures, and gestures to regulation social interaction
- ii. Failure to develop peer relationships appropriate to developmental level
- iii. A lack of spontaneous seeking to share enjoyment, interests, or achievement with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest to other people)
- iv. Lack of social or emotional reciprocity
- b. Restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:
 - i. Encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus
 - ii. Apparently inflexible adherence to specific, nonfunctional routines or rituals
 - iii. Stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements)
 - iv. Persistent preoccupation with parts of objects
- c. The disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning
- d. There is no clinically significant general delay in language (e.g., single words used by age 2 years, communicative phrases used by age 3 years)
- e. There is no clinically significant delay in cognitive development or in the development of age-appropriate self-help skills, adaptive behavior (other than in social interaction), and curiosity about the environment in childhood.
- f. Criteria are not met for another specific Pervasive Developmental Disorder or Schizophrenia
- 3. Pervasive Developmental Disorder Not Otherwise Specified (including atypical autism):
 - a. This category should be used when there is a severe and pervasive impairment in the development of reciprocal social interaction associated with impairment in either verbal or nonverbal communication skills or with the presence of stereotyped behavior, interests, and activities, but the criteria are not met for a specific Pervasive Developmental Disorder, Schizophrenia, Schizotypal Personality Disorder, or Avoidant Personality Disorder. For example, this category includes "atypical autism" presentations that do not meet the criteria for Autistic Disorder because of late age onset, atypical symptomatology, or subthreshold symptomatology or all of these.

ICD Classifications for ASD:

- 1. <u>ICD-9</u>: The ICD-9 is a previous version of the global standard for classifying diseases and medical conditions (WHO, *International Classification of Diseases, 9th Revision*, 1977) (ICD-9)). It was widely used by healthcare professionals and organizations until 2015, when it was replaced by the ICD-10 in many countries. In the ICD-9 coding system, autism was classified as "299.0 Infantile Autism." The diagnostic criteria were not explicitly provided within the coding system itself, since the ICD-9 system primarily focused on classifying and organizing diseases and disorders.
- 2. ICD-10: Autism is classified under ICD-10 Chapter V, "Mental and Behavioural Disorders, Disorders of Psychological Development (F8089)" (WHO, The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines, 1992 (ICD-10)). The disorders in Chapter V are described as having the following in common: "(a) onset invariably during infancy or childhood, (b) impairment or delay in development of functions that are strongly related to biological maturation of the central nervous system, and (c) a steady course without remission or relapses" (ICD-10). Autism is listed under the Pervasive Developmental Disorders ("PDD") subcategory, code F84, which includes eight different disorders. Notably, these PDDs are defined similarly as they were in the DSM-IV-TR, as "characterized by qualitative abnormalities in reciprocal social interactions and in patterns of communication, and by a restricted, stereotyped, repetitive repertoire of interests and activities. These qualitative abnormalities are a pervasive feature of the individual's functioning in all situations" (ICD-10). This system of discrete diagnoses is comparable to that in the DSM-IV-TR. However, the single Autism Spectrum Disorder category in the DSM-5 significantly contrasts the eight Pervasive Developmental Disorders in ICD-10.
- 3. <u>ICD-11</u>: The ICD-11 was adopted in 2019 but has not yet been implemented in the United States (WHO, *International Statistical Classification of Diseases and Related Health Problems*, 11th Revision, 2018 (ICD-11)). It includes updated criteria for autism spectrum disorders. Importantly, the ICD-11 criteria for autism differ slightly from the criteria used in other diagnostic systems such as the DSM-5. The diagnostic criteria for autism, Code 6A02–Autism Spectrum Disorder, in the ICD-11 are as follows:
 - i. Social Communication and Social Interaction Difficulties: Difficulty with social-emotional reciprocity, such as abnormal social approach, reduced sharing of interests or emotions, and difficulty with back-and-forth conversation.
 - Deficits in nonverbal communicative behaviors, such as abnormal eye contact, body language, and gestures.

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³ The eight different disorders are: Childhood Autism (F84.0); Atypical Autism (F84.1); Rett Syndrome (F84.2); Other Childhood Disintegrative Disorder (F84.3); Overactive Disorder Associated with Mental Retardation and Stereotyped Movements (F84.4); Asperger Syndrome (F84.5); Other Pervasive Developmental Disorders (F84.8); and Pervasive Developmental Disorder, Unspecified (F84.9).

- iii. Challenges in developing and maintaining relationships, including difficulty adjusting behavior to suit different social contexts and problems with imaginative play or making friends.
- b. Restricted and Repetitive Patterns of Behavior, Interests, or Activities:
 - i. Stereotyped or repetitive motor movements, use of objects, or speech.
 - ii. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior.
 - iii. Highly restricted, fixated interests that are abnormal in intensity or focus.
 - iv. Hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment.
- c. Symptoms must be present in early childhood but may not become fully manifest until social demands exceed limited capacities.
- d. Symptoms cause significant impairment in personal, social, educational, occupational, or other important areas of functioning.
- e. These difficulties are not better explained by intellectual disability or global developmental delay.

ICD-11 also discusses environmental, genetic and physiological risk and prognostic factors, in addition to culture- and gender-related diagnostic issues.

Appendix 2

DSM-5, DSM-IV, and ICD for ADHD

DSM-5 Criteria for ADHD:

A persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development, as characterized by inattention and/or hyperactivity and impulsivity.

- 1. <u>Inattention:</u> Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities. Note: The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or failure to understand tasks or instructions. For older adolescents and adults (age 17 and older), at least five symptoms are required.
 - a. Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or during other activities (e.g., overlooks or misses details, work is inaccurate).
 - b. Often has difficulty sustaining attention in tasks or play activities (e.g., has difficulty remaining focused during lectures, conversations, or lengthy reading).
 - c. Often does not seem to listen when spoken to directly (e.g., mind seems elsewhere, even in the absence of any obvious distraction).
 - d. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., starts tasks but quickly loses focus and is easily sidetracked).
 - e. Often has difficulty organizing tasks and activities (e.g., difficulty managing sequential tasks; difficulty keeping materials and belongings in order; messy, disorganized work; has poor time management; fails to meet deadlines).
 - f. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework; for older adolescents and adults, preparing reports, completing forms, reviewing lengthy papers).
 - g. Often loses things necessary for tasks or activities (e.g., school materials, pencils, books, tools, wallets, keys paperwork, eyeglasses, mobile telephones).
 - h. Is often easily distracted by extraneous stimuli (for older adolescents and adults, may include unrelated thoughts).
 - i. Is often forgetful in daily activities (e.g., doing chores, running errands; for older adolescents and adults, returning calls, paying bills, keeping appointments).
- 2. <u>Hyperactivity and impulsivity:</u> Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities. Note: The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or a failure to understand tasks or instructions. For older adolescents and adults (age 17 and older), at least five symptoms are required.
 - a. Often fidgets with or taps hands or feet or squirms in seat.

- b. Often leaves seat in situations when remaining seated is expected (e.g., leaves his or her place in the classroom, in the office, or other workplace, or in other situations that require remaining in place).
- c. Often runs about or climbs in situations where it is inappropriate, (Note: in adolescents or adults, may be limited to feeling restless).
- d. Often unable to play or engage in leisure activities quietly.
- e. Is often "on the go," acting as if "driven by a motor" (e.g., is unable to be or uncomfortable being still for extended time, as in restaurants, meetings; may be experienced by others as being restless or difficult to keep up with).
- f. Often talks excessively.
- g. Often blurts out an answer before a question has been completed (e.g., completes people's sentences, cannot wait for turn in conversation).
- h. Often has difficulty waiting his or her turn (e.g., while waiting in line).
- i. Often interrupts or intrudes on others (e.g., butts into conversations, games, or activities; may start using other people's things without asking or receiving permission; for adolescents and adults, may intrude into or take over what others are doing).

In addition, the following conditions must be met under the DSM-5:

- i. Several inattentive or hyperactive-impulsive symptoms were present prior to age 12 years.
- ii. Several inattentive or hyperactive-impulsive symptoms are present in two or more settings (e.g., at home, school, or work; with friends or relatives; in other activities).
- iii. There is clear evidence that the symptoms interfere with, or reduce the quality of, social, academic, or occupational functioning.
- iv. The symptoms do not occur exclusively during the course of schizophrenia or another psychotic disorder and are not better explained by another mental disorder (e.g., mood disorder, anxiety disorder, dissociative disorder, personality disorder, substance intoxication or withdrawal).

Based on the type of symptoms that are exhibited by the child, there are three different presentations of ADHD, which the clinician should specify:

- 1. <u>Combined presentation</u>: If both inattention and hyperactivity-impulsivity are met for the past 6 months.
- 2. <u>Predominantly inattentive presentation</u>: If inattention is met but hyperactivity-impulsivity is not met for the past 6 months.
- 3. <u>Predominantly hyperactive/impulsive presentation</u>: If hyperactivity-impulsivity is met, but inattention is not met for the past 6 months.

The clinician should also specify the severity of the symptoms and if the child is in partial remission.

ICD Classifications for HKD:

- 1. <u>ICD-9</u>: In the ICD-9, ADHD falls under the broader category of "Hyperkinetic Disorders." The specific ICD-9 codes related to ADHD are as follows: 314.0: Attention Deficit Disorder without mention of hyperactivity (predominantly inattentive type); and 314.1: Attention Deficit Disorder with hyperactivity (combined type, overactivity NOS, predominantly hyperactive/impulsive type, or simple disturbance of attention with overactivity).
- 2. <u>ICD-10</u>: In the ICD-10, ADHD is categorized under the section "Hyperkinetic Disorders (F90)." The ICD-10 code for ADHD is F90.0, known as "Disturbance of Activity and Attention." The term "attention deficit" encompasses various definitions such as attention deficit disorder with hyperactivity, attention deficit hyperactivity disorder, or attention deficit syndrome with hyperactivity (Doernberg & Hollander, 2016). Significantly, the ICD-10 excludes the diagnosis of ADHD when it coexists with HKD associated with conduct disorder (F90.1). Furthermore, pervasive developmental disorders are classified as exclusionary for HKD in the ICD-10. This contrasts with the DSM-5, which allows for a comorbid diagnosis of ADHD and autism.
- 3. <u>ICD-11</u>: As previously mentioned, ICD-11 has not yet been implemented in the United States despite its adoption in 2019. In ICD-11, hyperkinetic disorder was removed and renamed attention-deficit hyperactivity disorder (ADHD). ADHD is classified under the category of Neurodevelopmental Disorders and was given code 6A05-Attention Deficit Hyperactivity Disorder.

Appendix 3

Assessments for ASD and ADHD

The following assessments are used to assess for ASD and ADHD symptoms in children:

- A. Developmental and Well-Being Assessment (DAWBA): A novel package of questionnaires, interviews, and rating techniques designed to examine ICD-10, DSM-IV and DSM-5 diagnoses in individuals between the ages of 2 and 65 years old. Information is collected from up to three sources (1) interview with the parents of 2 to 17 year olds; (2) interview with 11to 17 year olds themselves; (3) questionnaires completed by teachers of 2 to 17 year olds (DAWBA | Youthinmind, n.d.; Goodman et al., 2000). Interviews can be completed via computer or in interview format. Common emotional, behavioral, and hyperactivity disorders in addition to severe disorders are examined. Validation studies have shown the DAWBA to be a good measure for both epidemiological studies and in clinic assessments. DAWBA has been shown to be an accurate and sufficient measure to assess for ADHD in clinical community settings, without direct patient contact by the diagnosing clinician (Foreman et al., 2009), and has good agreement with the Autism Diagnostic Interview – Revised (ADI-R), a gold standard diagnostic caregiver interview used to diagnose ASD (Murphy et al., 2018). Most importantly, this questionnaire can be completed without direct patient contact, making it ideal for community settings and largescale epidemiological studies.
- B. Child Behavior Checklist (CBCL): The CBCL is a component of the Achenbach System of Empirically Based Assessment (ASEBA), which is used to detect emotional, social and behavioral problems in children and adolescents (Mazefsky et al., 2011; School-Age (CBCL, TRF, YSR), n.d.). There are multiple versions of this questionnaire, including (1) parent/caregiver report form, (2) teacher's report form, and (3) youth self-report, which can be completed for different age groups including (1) ages 1 ½ to 5 years (parent/caregiver and teacher form), (2) ages 6 to 18 years (parent/caregiver and teacher form), (3) ages 11 to 18 years (youth self-report form). All forms were revised from their 1991 versions in 2000 or 2001. The preschool CBCL 1 ½ to 5 years forms include syndrome scales (emotionally reactive; anxious/depressed; somatic complaints; withdrawn; sleep problems; attention problems; aggressive behavior) and DSM-oriented scales (depressive problems, anxiety problems, autism spectrum problems; attention deficit/hyperactivity problems; oppositional defiant problems). The school-age CBCL 6 to 18 years and youth self-report 11 to 18 years include the following syndrome scales: anxious/depressed, withdrawn/depressed, somatic complaints, social problems, thought problems, attention problems, rule breaking behavior and aggressive behavior; and DSM-oriented scales: depressive problems, anxiety problems, somatic problems, attention deficit/hyperactivity problems, oppositional defiant problems, conduct problems. The CBCL 1 ½ to 5 years parent/caregiver and teacher forms DSM-ASD (previously DSM-pervasive developmental problems, DSM-PDD) subscale has been validated as a good Level 1 screener of ASD with good discriminatory questions and measurement invariance across multiple diverse populations (International ASEBA Consortium et al., 2020). Although ASD is not included in the syndrome scales for school-age children, the CBCL 6 to 18 years parent/caregiver and teacher forms have also been validated as appropriate screeners for ASD when

examining scores on specific subscales, including the Thought and Social Problems scales (Mazefsky et al., 2011), and the Withdrawn/Depressed, Social Problems and Attention Problems scales (Arias et al., 2022). The CBCL DSM-oriented subscale for ADHD and the Attention Problems subscale have both been validated as diagnostic measures and screeners for ADHD, with good predictability for later diagnoses of the disorder (Biederman et al., 2021; Oerbeck et al., 2020; Spencer et al., 2018).

- C. Childhood Autism Spectrum Test (CAST; formerly known as the Childhood Asperger Screening Test): CAST is a 37-item parent/caregiver questionnaire developed in 2002 as a screening measure for autism spectrum symptoms. The CAST measures difficulties and preferences in social and communication skills, including social interaction, reciprocity, eye contact, play activities, and restricted and repetitive behaviors. Validity and test-retest reliability has been examined in multiple large population-based observational studies that include samples from general populations of school-aged children. It shows good sensitivity and specificity for autism spectrum symptoms with a moderate positive predictive value. A cut-off point of 15 has been used; at this level there is a sensitivity of 100%, specificity of 50%, and positive predictive value of 50% (*The Childhood Asperger Syndrome Test (CAST)*, n.d.; J. Williams et al., 2005, 2006; J. G. Williams et al., 2008).
- D. Conners Parent Rating Scale- Revised short form (CPRS-R:S): The CPRS-R:S is a parent/caregiver report questionnaire to measure behavioral challenges in children and adolescents aged 3 to 17. The Conners rating scales include long and short forms that can be administered to children and adolescents. The short form has 27 items that parents/caregivers will rate on a Likert scale to indicate how often their child engages in the behaviors listed (never to very often). The Conners rating scales are useful for the assessment of children and adolescents with ADHD, as it assesses the 12 criteria listed in the DSM-IV for ADHD (Kumar & Steer, 2003). The ratings are summed to yield a 6-item oppositional, 6-item cognitive problems/inattention and 6-item hyperactivity scale. It also includes the ADHD Index, which includes items found to best discriminate youth with ADHD from neurotypical peers. The Conners rating scale system was revised as the Conners-3 in 2008 (Conners 3rd Edition, n.d.).
- E. Conners Kiddie Continuous Performance Test (Conners K-CPT): The Conners K-CPT is a computerized assessment that evaluates attention, function, reaction time, accuracy and impulse control. The original K-CPT was developed to evaluate ADHD symptoms in children aged 4 to 5 years. The K-CPT 2 was first developed in 2001, and is currently used for children ages 4 to 7:11 years old. There is also a version used in children 8 years and older, called the Conners Continuous Performance Test 3rd Edition (CPT-3), which was developed in 2014. Measures on the K-CPT include commission errors, omission errors, hit reaction time standard error and detectability. This measure is frequently used in epidemiological and clinical research, and the variables have been correlated to ADHD symptoms (Epstein et al., 2003; Conners et al., 2003; Breaux et al., 2016).
- F. <u>Strengths and Difficulties Questionnaire (SDQ)</u>: The SDQ is a 25-item questionnaire measuring emotional and behavioral difficulties in children and adolescents aged 4 to 17 years from the perspective of the parent/caregiver, teacher, or child/adolescent (aged 11 to

- 17). It can be used as both a screening or diagnostic measure, and as an outcome measure in treatment trials. The SDQ is widely used across the globe in both clinical and research settings, has been translated into 40 different languages, and has been well-validated in multiple populations. It has five scales scored from 0 to 10; emotional problems, conduct problems, hyperactivity, peer problems and prosocial behaviors. The scales are combined (minus the prosocial scale) into a "total difficulties" score (0 to 40). The SDQ is shown to be a valid tool for discriminating cases with ADHD from those without ADHD or with other mental health diagnoses in large population-based studies, including those that had confirmed diagnoses via a medical/healthcare professional (Algorta et al., 2016; Russell et al., 2013). It has also been studied in ASD populations and in individuals with co-morbid ASD and ADHD, with good sensitivity and specificity reported.
- G. <u>The DSM-ADHD Questionnaire:</u> Symptom checklists have been developed for ADHD and other disorders based on their diagnostic criteria in the DSM (DSM-IV, DSM-IV-TR, DSM-5). The DSM nosology has been validated as a way to differentiate symptoms and diagnose preschoolers, in addition to older children and adults (Sterba et al., 2007).

The foregoing opinions are substantively identical to the opinions stated in my June 16, 2023 report. All opinions offered herein are held to a reasonable degree of scientific certainty.

Dated: June 22, 2023

Respectfully submitted,

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RULE 26 GENERAL CAUSATION EXPERT REPORT OF DR. ERIC HOLLANDER, M.D., DFAPA, FACNP

Materials Considered

Expert Reports:

Expert Report of Dr. Andrea Baccarelli, M.D., PhD

Expert Report Dr. Robert Cabrera, PhD Expert Report Dr. Stan Louie, PharmD

Expert Report Dr. Brandon Pearson, MSc, PhD

Depositions:

Deposition of Carol Jeffcoat (5/25/2023) and Attached Exhibits Deposition of Edwin Kuffner (5/24/2023) and Attached Exhibits Deposition of Islah Ahmed (6/1/2023) and Attached Exhibits Deposition of Leslie Shur (5/26/2023) and Attached Exhibits Deposition of Rachel Weinstein (5/19/2023) and Attached Exhibits

Drug Labels:

Depakote Label (2023)

Paracetamol 500mg Tablets (POM) Label

Ultracet Label

Tylenol Acetaminophen Extra Strength Label

Tylenol Regular Strength Label

TYLENOL® Professional. "Safety Profile of TYLENOL®." Accessed June 16, 2023.

https://www.tylenolprofessional.com/safety-and-efficacy/safety.

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Accessed March 23, 2023. https://www.tylenolprofessional.com/adult-dosage.

FDA Documents:

All FDA Productions in This Case

FDA, Acetaminophen: Background and Overview (6/29/2009)

FDA, Drug Therapeutics & Regulation in the U.S. (1/31/2023),

https://www.fda.gov/about-fda/fda-history-exhibits/drug-therapeutics-regulation-us

Internal Analgesic, Antipyretic, and Antirheumatic Drug Products for Over-the-Counter Human Use; Tentative Final Monograph, 53 FR 46204-01, 1988 WL 275236 (F.R.)

Ofirmev FDA Drug Approval Package,

https://www.accessdata.fda.gov/drugsatfda docs/nda/2010/022450 ofirmev toc.cfm.

JJCI-Produced Documents:

Company Core Data Sheets, including:

Company Core Data Sheet (APAP-JJCI-0000269165-95)

Company Core Date Sheet Version 2.0 (APAP-JJCI-0000749925-974)

Company Core Date Sheet Version 3.0 (APAP-JJCI-0000269231-250)

Company Core Date Sheet Version 4.0 (APAP-JJCI-0000269251-271)

Company Core Date Sheet Version 5.0 (APAP-JJCI-0000269272-300)

Company Core Date Sheet Version 6.0 (APAP-JJCI-0000241259-287)

Company Core Date Sheet Version 7.0 (APAP-JJCI-0000208431-464)

Periodic Benefit Risk Evaluation Report/Periodic Safety Update Report (APAP-JJCI 0000753540)

Project Cocoon Forest Plots, Redrawn

Project Cocoon Nonsystematic Reviews

Project Cocoon Update, August 2022

Project Cocoon Repro Slides

Suarez, et al. Article (APAP-JJCI-0000206374-85)

Laws, Regulations, and Rules:

21 C.F.R. 201

Federal Register, Vol. 73, No. 104 (May 29, 2008)

Federal Food, Drug, and Cosmetic Act Amendments (Durham-Humphrey amendments), Pub. L. No. 82-215, 65 Stat. 648 (1951).

Scientific Articles & Other Publications:

- "A 14-Month Randomized Clinical Trial of Treatment Strategies for Attention-Deficit/Hyperactivity Disorder." *ARCH GEN PSYCHIATRY* 56 (1999).
- "A Review of the Pathophysiology, Etiology, and Treatment of Attention-Deficit Hyperactivity Disorder (ADHD)." Accessed May 17, 2023. https://doi.org/10.1177/1060028013510699.
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